Department of Health and Mental Hygiene

Mental Hygiene Administration

IMPLEMENTATION REPORT OF THE FY 2012 ANNUAL STATE MENTAL HEALTH PLAN

A CONSUMER – ORIENTED SYSTEM

MARTIN O'MALLEY, GOVERNOR

ANTHONY G. BROWN, LIEUTENANT GOVERNOR

JOSHUA M. SHARFSTEIN, M.D., SECRETARY

GAYLE JORDAN-RANDOLPH, M.D., DEPUTY SECRETARY
BEHAVIORAL HEALTH AND DISABILITIES

BRIAN M. HEPBURN, M.D., EXECUTIVE DIRECTOR

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MARYLAND MENTAL HYGIENE ADMINISTRATION
Spring Grove Hospital Center ♦ 55 Wade Avenue ♦ Dix Building
Catonsville, Maryland 21228
410.402.8300 ♦ FAX 410.402.8309 ♦ MD Relay 1.800.735.2258
www.dhmh.state.md.us/mha/

ACKNOWLEDGEMENTS

As in the past, the FY 2012 State Mental Health Plan is the result of the hard work of many people, particularly the Mental Hygiene Administration (MHA) staff, consumers, mental health advocacy groups, the Planning Committee of the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council and representatives of the Core Service Agencies. However, during the past two years the participation in the development of this annual plan was much increased through additional organizational and community stakeholders who gave their time to review and offer input into this document through all day Mental Health Plan Development Meetings held in the spring. This year, on April 29, 2011 the gathering included representatives of:

Consumers, including members of the Deaf and Hard of Hearing community

Family members

Consumer, child and family advocacy organizations

Wellness and Recovery Centers

Mental health providers and provider organizations

Local Mental Health Advisory Committees

Maryland Association of Core Service Agencies

Core Service Agencies' Boards of Directors

Protection and Advocacy Agencies

The Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Maryland Blueprint Committee

The Traumatic Brain Injury Advisory Board

DHMH and other Maryland state agencies

MHA staff and the Mental Health Transformation Office

Other interested stakeholders and citizens of Maryland

We at MHA thank all of you who contributed to the development of this plan and look forward to continued collaboration as we proceed with our goals and future endeavors. The use of break-out groups, as well as the availability of and interaction among key MHA staff and stakeholders, allowed much to be accomplished in a limited period of time. While not all suggestions were able to be included in the final document, some due to budget and resource constraints, many of the concepts prioritized by the break-out groups are expressed, at least in part, in a number of strategies. Your input and participation, through the group discussions and interactive process, have been invaluable.

STATE OF MARYLAND MENTAL HYGIENE ADMINISTRATION

MISSION
The Department of Health and Mental Hygiene's Office of Behavioral Health and Disabilities will develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions and developmental disabilities. The Mental Hygiene Administration will, through publicly funded services and supports, promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders.

THE VISION
The Vision of our public mental health system is drawn from fundamental core commitments:
- Coordinated, quality system of care
- A full range of services available
- Seamless linkages to services for the consumer delivered through a system of integrated care
- Recognition that co-occurring and co-morbid conditions are the norm
- Focus on treatment, behavioral health, support, recovery, and resilience
- Services developed in collaboration with culturally competent stakeholders in an environment that is culturally sensitive
- Improved health, wellness, and quality of life for consumers

VALUES
The values underpinning this system are:
(1)   BASIC PERSONAL RIGHTS
   Persons with psychiatric disabilities have the same rights and obligations as other citizens of the state. Consumers have the right to choice, to retain the fullest possible control over their own lives, and to have opportunities to be involved in their communities.

(2)   RESPONSIVE SYSTEM
   The Public Mental Health System must be responsive to the people it serves, coherently organized, and accessible to those individuals needing mental health care. Information must be readily available for individuals to enter and proceed through the system in a more appropriate and timely manner. The hospitals are one part of the community-based mental health system. The Public Mental Health System must collaborate with other public and private human health service systems in order to allow for continuity of care and facilitate support with all activities of life.

(3)   EMPOWERMENT
   Consumers, families, and advocates will be involved in decision-making processes, individually at the treatment level and collectively in the planning and operational aspects of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Relevant programs and services that recognize varying cultural, ethnic, and racial needs are imperative.

(4)   ***FAMILY AND COMMUNITY SUPPORT***
We must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. We will strive to provide services to persons within their communities with the availability of natural/family supports.

(5)   ***LEAST RESTRICTIVE SETTING***
An array of services will be available throughout the state to meet a variety of consumer needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.

(6)   ***WORKING COLLABORATIVELY***
Collaborations with other agencies at the state and local level will be fostered so support to consumers is inclusive of all activities of life. This will promote a consistently appropriate level of mental health services.

(7)   ***EFFECTIVE MANAGEMENT AND ACCOUNTABILITY***
Accountability is essential to consistently provide an adequate level of mental health services. Essential management functions include monitoring and self-evaluation, responding rapidly to identified weaknesses in the system, adapting to changing needs, and improving technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.

(8)   ***LOCAL GOVERNANCE***
Local management of resources, resulting from the implementation of Core Service Agencies, will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources with needs, and increase economic efficiency due to the closer proximity of the service delivery level.

(9)   ***STAFF RESOURCES***
The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.

(10)   ***COMMUNITY EDUCATION***
Early identification and prevention activities for risk groups of all ages, public education, and efforts that support families and communities must be incorporated into our service system. Increased acceptance and support for mental health services come from increased awareness and understanding of psychiatric disorders and treatment options.

List of Acronyms

ACT	Assertive Community Treatment
ADAA	Alcohol and Drug Abuse Administration
ASO	Administrative Services Organization-ValueOptions®Maryland
BIPP	Balancing Incentive Payments Program
CBH	Community Behavioral Health Association of Maryland
CCAC	Cultural and Linguistic Competence Advisory Committee
CHIPRA	Children's Health Insurance Program Reauthorization Act
CILS	Centers for Independent Living
CLCTI	Cultural and Linguistic Competency Training Initiative
CME	Care Management Entity
CMS	Centers for Medicare and Medicaid Services
COD	Co-occurring disorder
COOP	Continuity of Operations Plan
CSA	Core Service Agency
CSEFEL	Center on the Social and Emotional Foundations for Early Learning
CQT	Consumer Quality Team
DDA	Developmental Disabilities Administration
DDC	Dual Diagnosis Capability
DHCD	Maryland Department of Housing and Community Development
DHMH	Maryland Department of Health and Mental Hygiene
DHR	Maryland Department of Human Resources
DJS	Maryland Department of Juvenile Services

DORS	Division of Rehabilitation Services
DPSCS	Department of Public Safety and Correctional Services
DSS	Department of Social Services
EBP	Evidence-Based Practice
EBPC	Evidence-Based Practice Center
F2F	Family-to-Family
FLI	Family Leadership Institute
FPE	Family Psycho-Education
GOC	Governor's Office for Children
HCBS	Home and Community-Based Services
HCRCC	Maryland Health Care Reform Coordinating Council
HMIS	Hospital Management Information System
HSCRC	Health Services Cost Review Commission
HTI	Healthy Transitions Initiative
HUD	Housing and Urban Development
IFSC	Interagency Forensic Services Committee
IRMA	Information Resource Management Administration
IT	Information Technology
LEAP	Leadership Empowerment and Advocacy Project
LMHAC	Local Mental Health Advisory Committee
LGBTQ	Lesbian, gay, bi-sexual, transgender, questioning
LMB	Local Management Board
MA	Medical Assistance or Medicaid

MACSA	Maryland Association of Core Service Agencies
MARFY	Maryland Association of Resources for Families and Youth
MCCJTP	Maryland Community Criminal Justice Treatment Program
MCF	Maryland Coalition of Families for Children's Mental Health
MCO	Managed Care Organization
MDLC	Maryland Disability Law Center
MDoA	Maryland Department of Aging
MDOD	Maryland Department of Disabilities
MDOT	Maryland Department of Transportation
MEMA	Maryland Emergency Management Administration
MFP	Money Follows the Person
MHA	Mental Hygiene Administration
MHAMD	Mental Health Association of Maryland, Inc.
MHCC	Maryland Health Care Commission
MHCJP	Mental Health & Criminal Justice Partnership
MMHEN	Maryland Mental Health Employment Network
MHFA	Mental Health First Aid
MHT-SIG	Mental Health Transformation State Incentive Grant
MI	Motivational Interviewing
MIS	Management Information Systems
MPAH	Maryland Partnerships for Affordable Housing
MSDE	Maryland State Department of Education
NAMI MD	National Alliance on Mental Illness-Maryland

NASMHPD	National Association of State Mental Program Directors
NIMS	National Incident Management System
NOC	Network of Care
NOFA	Notice of Funding Availability
OCA	MHA Office of Consumer Affairs
ODHH	Governor's Office of the Deaf and Hard of Hearing
OETAS	Office of Education and Training for Addiction Services
OFS	MHA Office of Forensic Services
OHCQ	Office of Health Care Quality
OMHC	Outpatient Mental Health Clinic
OMS	Outcome Measurement System
OOOMD	On Our Own of Maryland, Inc.
PAC	Primary Adult Care
PATH	Projects for Assistance in Transition from Homelessness
PCC	Person Centered Care
PERS	Peer Employment Resource Specialist
PHA	Local Public Housing Authorities
PMHS	Public Mental Health System
PRP	Psychiatric Rehabilitation Program
PRTF	Psychiatric Residential Treatment Facility
PTSD	Post Traumatic Stress Disorder
RRP	Residential Rehabilitation Program
SAMHSA	Substance Abuse and Mental Health Services Administration

SDC	Self-Directed Care
SE	Supported Employment
SEC	Systems Evaluation Center
SED	Serious Emotional Disorders
SMI	Serious Mental Illness
SOAR	Supplemental Social Security, Outreach, Access, and Recovery
SOC	System of Care
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TAC	Technical Assistance Collaborative, Inc.
TAMAR	Trauma, Addiction, Mental Health, and Recovery
TAY	Transition-Age Youth
TBI	Traumatic Brain Injury
TTW	Ticket-to-Work
UMBC	University of Maryland – Baltimore County
VA	Veterans Administration
WRAP	Wellness Recovery Action Plan
Youth MOVE	Youth Motivating Others through Voices of Experience

SYSTEM GOALS
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These Mental Hygiene Administration (MHA) goals, objectives, and strategies are a result of the collaborative efforts related to the implementation of the five-year federal Mental Health Transformation State Incentive Grant (MHT-SIG), existing interagency cooperation, and public and private partnerships. These alliances have been strengthened and new partnerships formed to further build upon the infrastructure, coordinate care, and improve service systems. Mental health transformation efforts and activities have fostered the implementation of increased opportunities for public education; awareness; training of consumer, families, and mental health professionals; and support of employment, self-directed care, and affordable housing options. Advancement and sustainment of these efforts will be effectively amplified through the support of Web-based technology that increases awareness and linkages to services; promotes wellness, prevention, and diversion activities; and enhances efforts in evidence-based and promising practices as well as cultural competency. These advancements are infused throughout the MHA State Mental Health Plan for children, adolescents, and adults. As the MHT-SIG completes its final year, MHA strategies continue to involve effective and efficient collaborations to support sustainability of transformation gains that promote recovery and resiliency; and will continue to evolve over the next few years as health care reform becomes fully implemented.

To continue improvement in the delivery of prevention, treatment and recovery support services, the Substance Abuse and Mental Health Services Administration (SAMHSA) has identified Eight Strategic Initiatives to focus the Agency's efforts toward promoting expansion of behavioral health. MHA has organized its FY 2012 plan activities based on these initiatives. (Listed in Appendix A)

Objective 1.1. The Mental Hygiene Administration (MHA), in collaboration with the Core Service Agencies (CSAs), will continue to work with the mental health community to initiate educational activities and disseminate, to the general public, current information related to psychiatric disorders, prevention mechanisms, treatment services, and supports.

(1-1A)   *Federal Mental Health Block Grant*
MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Missouri Department of Health, and the National Council for Community Behavioral Health, will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland and throughout the United States.
Indicators:
- Continued publication, distribution, and promotion of Mental Health First Aid Participant Manual and Teaching Notes
- Work continued with Mental Health Association of Maryland, Inc. (MHAMD), national partners, and advocates to finalize a MHFA USA Youth Manual and teaching notes
- Curriculum supplements developed and piloted for workplace, law enforcement, military/veterans, primary care, assisted and aging living, faith communities, and higher education
- Continued partnership with MHAMD and CSAs to deliver additional training to local Area Offices on Aging, Department of Social Services, law enforcement, parole and probation, judges, public health, Emergency Medical Services personnel, shelter workers, higher education, and state employees
- Program sustained through course fees and other funding sources

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Cynthia Petion and Carole Frank, MHA Office of Planning and Training; DHMH; CSAs; Mental Health Association of Maryland (MHAMD); Maryland Coalition of Families for Children's Mental Health; On Our Own of Maryland; Missouri Department of Mental Health; the National Council for Community Behavioral Health; other mental health advocacy groups

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Mental Health First Aid (MHFA) Program, a 12-hour course that teaches lay people methods of assisting someone who may be in the early stages of developing a mental health problem or in a mental health crisis situation, continued to expand in FY 2012. The MHFA is a collaborative implementation through three national partners: Maryland Department of Health and Mental Hygiene (DHMH), Missouri Department of Mental Health, and the National Council for Community Behavioral Health. Maryland's efforts are led by the Mental Health Association of Maryland (MHAMD). Maryland has been a national leader in adapting MHFA for American audiences (the original MHFA program was developed in Australia). More than 75,000 copies of the manuals and 1,500 instructor teaching kits have been produced and distributed nationally. In Maryland, more than 80 certified instructors have been trained during FY 2012 bringing the total to 179 instructors. The groups that have participated in MHFA trainings include criminal justice staff, administrative law judges, human resources professionals, Core Service Agencies, behavioral health organizations, and students, faculty, and staff at a number of colleges and universities across the state. The total number of Maryland residents trained in MHFA now exceeds 3,500 people. It is expected that trainings in Maryland will continue beyond FY 2012, sustained through course fees, sales of manuals, and grants. A Web-based MHFA USA training has been developed to increase access and availability for the general public.

Maryland's leadership has resulted in expressions of interest in MHFA from a number of other states. On a national level, a series of 20 podcasts were taped and presented nationally on a regular basis through the Community Health Charities' "Health Matters at Work" program, promoting MHFA in the workplace. Curriculum supplements for workplace, law enforcement, military/veterans, primary care, assisted and aging living, faith communities, and higher education are being piloted. In Maryland a law enforcement and curriculum supplement has been piloted so far in Howard County. The higher education supplement has been piloted at the University of Maryland at Baltimore County (UMBC) and at Chesapeake College.

Additionally, in the summer/fall of 2012, the national partners have worked collaboratively in the development of a Youth Mental Health First Aid teaching kit and participant manual. The teaching kit will be comprised of the MHFA Youth Participant Manual, Youth Teaching Notes, Youth Power Point, Youth Flash Drive and Handouts, Youth DVDs, Youth Portfolio and Pens and Wallet cards. The MHAMD will be involved in the materials design, editing, production, and distribution of the Youth Participant Manual.

Strategy Accomplishment:
This strategy was achieved.

(1-1B)

MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.

<u>Indicators</u>: Activities include:

- Maryland Coalition of Families for Children's Mental Health's (MCF) and Mental Health Association of Maryland's (MHAMD's) Children's Mental Health Awareness Campaign – "Children's Mental Health Matters"; number of public service announcements aired, volume of literature disseminated, and other outreach activities implemented
- National Alliance on Mental Illness (NAMI MD) – NAMI WALK, Family to Family, and other education programs
- On Our Own Maryland, Inc. (OOOMD) – Anti-Stigma Project workshops
- Network of Care – promotion and usage
- MHAMD – outreach campaign for older adults
- CSA – outreach/media campaigns
- Wellness and Recovery Centers – outreach efforts

<u>Involved Parties</u>: Cynthia Petion and Robin Poponne, MHA Office of Planning, and Training; Al Zachik, MHA Office of Child and Adolescent Services; James Chambers, MHA Office of Adult Services; MHA Office of Forensic Services; Melissa Schober, MHA Medicaid Policy Analyst**;** Clarissa Netter, MHA Office of Consumer Affairs; appropriate MHA staff; CSAs; Maryland Coalition of Families for Children's Mental Health; MHAMD; NAMI MD; OOOMD; Wellness and Recovery Centers; community providers

<u>MHA Monitor</u>: Robin Poponne, MHA Office of Planning and Training

FY 2012 activities and status as of 6/30/2012 (end-year report):
These projects are ongoing:

Children's Mental Health Matters
This year MCF and MHAMD continued the partnership to promote the successfully received *Children's Mental Health Matters* awareness campaign. This social marketing effort is designed to build a network of information and support for families across Maryland and raise awareness of children's mental health. The two organizations have initiated a "Call to Action" to all stakeholders, requesting their participation in and support of this project. Since FY 2011, more than 100 professional associations, advocacy organizations and provider associations have signed on as Campaign partners. By establishing partnerships with stakeholders and other concerned organizations, recognition of Children's Mental Health Awareness Week has been increased and enhanced. This year on May 9th, to celebrate this special awareness week, MCF presented a dance event known as a "flash mob" or "dance attack", at the Inner Harbor in which more than 100 participants comprised of parents, youth, providers, and other stakeholders gathered to surprise unsuspecting spectators by performing a pre-learned dance routine to call attention to children's mental health matters and present resource information to the audience and community at large through media coverage.

Campaign kits/tools, including awareness ribbons, bracelets, posters, window clings, brochures, and calendars, are shared with the public through campaign collaborators and the CSAs. In addition to traditional print and broadcast media, social media tools such as the Web site, Google Calendar, and Facebook Page will continue to be utilized to disseminate information. The Web site also features resources to tackle issues such as bullying and a Webinar in May 2012 provided an overview of bullying among students with disabilities, with a focus on policy guidelines to help protect this vulnerable population. The campaign continues its partnership with local broadcast affiliates, radio and television. Public service announcements (PSAs) were once again aired in FY 2012 and will also be featured on all of the stations Web sites. The campaign's Web site is www.childrensmentalhealth.org.

NAMIWALKS
MHA works with NAMI MD and other stakeholders to support NAMIWALKS, a kick-off event for successfully promoting *MAY MENTAL HEALTH MONTH*. Representatives from MHA attended meetings and advance events to promote and launch NAMIWALKS. In 2012, NAMI WALKS occurred as a two-part event. On May 6th, the walk took place in Silver Spring, Montgomery County and on May 19th the walk took place at the Inner Harbor in Baltimore City. Estimated attendees for both walks numbered 4,200.

The awareness walks are designed to highlight the importance of education, advocacy, and support for persons diagnosed with a serious mental illness and their families. This annual event also helps reduce stigma often associated with mental illness by providing an opportunity for positive interactions and networking. The National Alliance on Mental Illness' peer and family support education programs offer unique, experiential learning programs for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. In FY 2012, 276 participants completed the Family-to-Family Education Programs.

The Anti-Stigma Project
On Our Own of Maryland, Inc. (OOOMD) and MHA will continue to collaborate efforts to fight stigma within the mental health system through the Anti-Stigma Project (ASP). In FY 2012, the ASP presented 51 workshops throughout the state, which trained 927 people in the full program and reached at least 259 additional participants at various venues such as psychiatric rehabilitation programs, housing authorities, homeless shelters, statewide conferences, and universities. Workshops may be designed and tailored to address specific populations and situations. A new workshop has been added on internalized stigma, "An Inside Look at Stigma," as well as a workshop on creating non-stigmatizing environments.

Through resources from the Mental Health Transformation – State Incentive Grant (MHT-SIG), ASP collaborated with researchers to evaluate the quantitative impact of this training project and its possibilities as a best or promising evidence-based tool. Results from the evaluation allowed OOOMD to enhance this program and continue training across the country.

Network of Care
The Maryland Network of Care (NOC) for Behavioral Health continues to enhance Maryland residents' ability to access consumer-driven, recovery-oriented and community-specified information regarding available mental health services in all of Maryland's 24 jurisdictions. Specialized service information is provided for Maryland's Youth as well as a special portal for Veterans and families to help service men and women returning from Iraq and Afghanistan with behavioral issues, obtain access to services. Core Service Agencies (CSAs) have been encouraged to support, at the county level, the expansion and promotion efforts of Network of Care. The use of NOC is encouraged and fostered in the Wellness and Recovery Centers, as well as other community settings, and plans are underway to train peer support specialists and peer educators to be able to train consumers on the use of NOC. Many consumers have received on-site training in the utilization of personal health record features and in the use of individual advance directives.

In FY 2012, the Maryland Network of Care for Behavioral Health recorded 2,519,079 sessions. The veterans' portal recorded over 159,381 during the same time period. (www.maryland.networkofcare.org).

Outreach Campaign for Older Adults
On January 5, 2012, through the Mental Health Association of Maryland's (MHAMD) "Coalition on Mental Health and Aging," the state level staff of MHA, Maryland Department of Human Resources (DHR), Maryland Department of Aging (MDoA) work hand-in-hand with the Coalition membership to jointly plan opportunities, cross-trainings, client sharing responsibilities, and opportunities for additional partnerships. "Mental Health in Later Life: a Guidebook for Older Marylanders and the People Who Care for Them" was produced by the MHAMD to bring education and resources regarding important issues of mental health and aging to older Marylanders, caregivers, and helping professionals. The Portable Document Format (PDF) version of the guidebook is available on MHAMD's mental health and aging Web site at www.mdaging.org .

Through the MHA-sponsored Adult Services Conference on Aging, the Director of the Coalition, in collaboration with geriatric specialists and MHA staff, provided training on issues of older adults in the areas of person centered care, Health Care Reform, trauma-informed care, and grief and loss. Approximately 65 people attended comprised of MDoA and DHR representatives, providers, consumers, and family members.

Several CSAs also provide training, outreach, and consultation to various community settings with older adult involvement. As appropriate, MHAMD folds Mental Health Advance Directive education into programs and trainings to both providers and consumers.

Strategy Accomplishment:
This strategy was achieved.

(1-1C)
Continue efforts to enhance communication and education through use of social media tools and networks.
Indicators:
- Social media outlets, such as Facebook or Twitter, utilized to promote public mental health awareness and improved communication among MHA, CSAs, providers, advocates, consumers, and family members
- At a minimum, throughout the fiscal year, produce 12-15 micro-blogs pertaining to mental health efforts and information
- Continue exploration of appropriate social media outlets to bolster Child and Adolescent initiatives and/or to provide Peer-to-Peer support

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems (MIS) and Data Analysis

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA, through DHMH departmental-wide efforts, established social media outlets through Facebook and Twitter as a means of disseminating mental health data and news among MHA, CSAs, providers, advocates, consumers, family members, and the public at large.

MHA has an individual Twitter account @DHMH_MHA. Since FY 2011, MHA has posted tweets on information ranging from Consumer Handbook and Reference Guide content to news items regarding SmartPhone applications used to diagnose post-traumatic stress disorder (PTSD) by Veterans. The account currently is "following" 73 other Twitter accounts relating to governmental, public health and mental health issues. The account is being "followed" by almost 190 other accounts all which, by virtue of their accounts, disseminate the information tweeted to their resources.

Both social media sites are robust with information provided by the DHMH Secretary, staff, and other stakeholders that are involved with the administration. Monthly data, regarding the increase in the number of followers to the @DHMH_MHA account, are submitted via StateStats. As new technology emerges, MHA will continue to explore appropriate social media outlets to bolster child and adolescent initiatives. The Maryland Coalition of Families for Children's Mental Health (MCF) developed Facebook pages for MCF and for the Children's Mental Health Awareness Campaign. The Campaign page is currently being enhanced to expand active participation in 2013.

Strategy Accomplishment:
This strategy was achieved.

(1-1D)

MHA, in collaboration with the Core Service Agencies (CSAs) will have an all-hazards approach to emergency preparedness and response for MHA as an administration (including facilities) and for the mental health community at large.

Indicators:

- Continued use of National Incident Management System (NIMS)
- Incident Command System (ICS) Chart maintained, NIMS/ICS training for Incident Command Team completed
- Ongoing training for new members
- All-Hazards Disaster Mental Health Plan updated, Continuity of Operations Plan (COOP) for Pandemics and a general COOP plan updated
- Facility Evacuation Plans and Mass Fatalities Plans for MHA facilities developed and implemented
- The mass fatalities equipment purchased and stored in a central location accessible to DHMH facilities around the state
- MHA evacuation and Mass Fatalities plans exercised, in collaboration with the University of Maryland, across the state
- Plans of correction developed as needed
- Multi-state Consortium and Brain Tree Solution as a resource

Involved Parties: Arlene Stephenson, MHA Office of the Deputy Director of Facilities Management and Administrative Operations; Marian Bland, MHA Office of Special Needs Populations; Gail Wowk, MHA Emergency Preparedness; Facilities CEOs; Hospital Emergency Managers; CSAs

MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director of Facilities Management and Administrative Operations

FY 2012 activities and status as of 6/30/2012 (end-year report):

Currently, MHA's All Hazards Plan and Continuity of Operations Plan (COOP), both General and Pandemic, are up-to-date. All Hazards plans for psychiatric facilities are updated annually and each facility exercises elements of its plan at least two times per year, which leads to modifying or updating the statewide Emergency Operations Plan. MHA's Office of Special Needs Populations reviews, facilitates updates to, and assists in the revision of the All-Hazards Mental Health Disaster Plans for MHA and all the Core Service Agencies. The Office also provides training to the Maryland Professional Volunteer Corps (MPVC) disaster behavioral health volunteers.

MHA has retained the University of Maryland Center for Health and Homeland Security to conduct evacuation exercises at each of the seven state psychiatric facilities beginning in FY 2011 and concluding in FY 2012, so that all DHMH facilities will benefit and use lessons learned to enhance future evacuation plans. Each facility was given a scenario whereby the facility needed to be evacuated quickly. The facilities activated their Incident Command System to handle the emergency and activated their Emergency Operations Plan and Evacuation Plan. Each Facility was asked to develop a working agreement with the Department of Public Safety and Correctional Services to assist with the evacuation of the forensic patients and during the exercises actually moved/evacuated 10% of their patient population.

All Hazards Planning is a continuous process broken down into four phases. The phases of this cycle are Preparedness, Response, Recovery, and Mitigation. At the end of each cycle, an improvement plan to address or modify actions, as needed (if possible), is submitted.

National Incident Management System/Incident Command System (NIMS/ICS) training has been completed by all MHA essential personnel according to the Federal Emergency Management Administration (FEMA) requirements. MHA and the Developmental Disabilities Administration (DDA) have shared their plans and ICS organization chart with each other should one need to act on behalf of the other. Additionally, mass fatality equipment, such as storage and identification tools, has been purchased and is stored at a central location in the state. Key staff at the facilities have attended a training on how to set up and use the equipment.

Additionally, MHA has been working with the FEMA Region III Disaster Behavioral Health Coordinators and Braintree Solutions Consulting, Inc. to examine the newly developed disaster behavioral mental health operational plan template created for the Region III states and the best practices disaster behavioral mental health training curriculum.

Strategy Accomplishment:
This strategy was achieved.

Objective 1.2. MHA will continue efforts that facilitate recovery, build resiliency, and develop mechanisms to promote health and wellness across the lifespan.

(1-2A)   *Federal Mental Health Block Grant
MHA, in collaboration with On Our Own of Maryland (OOOMD), will support statewide activities promoting the continuance of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.
Indicators:
- Two facilitator follow-up trainings held
- Statewide wellness and recovery trainings for providers conducted
- Continued implementation of WRAP training in local consumer peer support and advocacy organizations across Maryland such as Wellness and Recovery Centers
- Continued training of Olmstead Peer Support Specialists as an additional WRAP resource for hospital discharge planning

Involved Parties: Clarissa Netter and Susan Kadis, MHA Office of Consumer Affairs; OOOMD; CSAs; Wellness and Recovery Centers
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA, in collaboration with the CSAs, has supported On Our Own of Maryland's (OOOMD) initiative to transform its consumer network toward a wellness and recovery-oriented system. With the implementation of Wellness and Recovery Action Plans (WRAP), enhanced peer support activities and the use of best practices within the community have evolved. More than 2,700 people have participated in the WRAP orientation.

WRAP trainings have been instituted in the peer specialists training module developed by the Maryland Association of Peer Support Specialists and WRAP is incorporated into all consumer-run Wellness and Recovery Centers as a model for peer support. Peer advocates and participants in the Self Directed Care program have also received the WRAP training with an emphasis on stress reduction and wellness. As the trainings in the Wellness and Recovery Centers expand, OOOMD will continue to track and offer technical assistance upon request. In FY 2012, two 3-day trainings were held, one in March and one in June, attended by consumers and providers. Maryland now has more than 100 WRAP facilitators trained in a four-year period.

In the fall of FY 2012, three facilitator follow-up trainings were held; one in western Maryland, one on the Eastern Shore, and one in the central region attended by 32 mental health providers and consumers across the state.

One WRAP project received a grant from the Krieger Fund for $12,500 to train facilitators in Baltimore City in FY 2013.

Strategy Accomplishment:
This strategy was achieved.

(1-2B)
Continue to implement, evaluate, and refine the Self–Directed Care project in Washington County and throughout the state.
Indicators:
- Self-directed care plans developed and approved with peer support workers assisting consumers with the process
- Continued WRAP training of consumer advocates and consumer participants with an emphasis on stress reduction and wellness
- Increased Internet availability provided – Network of Care and use of advance directives for mental health treatment

Involved Parties: Clarissa Netter, MHA Office of Consumer Affairs; MHA staff; CSAs; Washington County CSA and providers; OOOMD; consumers and family members
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA implemented a consumer self-directed care pilot program in Washington County, managed through the local Office of Consumer Advocates. The Self-Directed Care (SDC) program assisted 101 individuals with the development of their plans over this year. At any one time, 45 individuals are active with the program. Staffing consists of two full-time and one part-time Peer Advocates assisting consumers with the process. Peer Advocates help consumers develop and implement their own "recovery plans", which include directing the use of their benefits to access both public mental health services and non-traditional support services such as driver education, gym memberships, and continuing education classes. If needed, SDC consumer funds pay for non-traditional resources such as classes, project-related clothing, textbooks, etc. Several consumers are in college and on the Dean's list. Additionally, individuals in the SDC program learn to independently manage their personal finances and are in various stages of developing or applying a plan for financial stability. In FY 2013, work incentive workshops will be held to promote awareness of employment benefits opportunities.

As part of the Office of Consumer Advocates, Inc. (OCA, Inc.), an affiliate of On Our Own of Maryland that operates in Washington, Allegany, and Garrett counties, SDC has Peer Advocates who are trained in WRAP and who offer WRAP classes, as needed, to the individuals who utilize OCA, Inc. services. WRAP and the other classes/ activities offered through OCA, Inc. emphasize stress reduction and promote wellness and recovery. Individuals who are active in SDC and other OCA, Inc. programs are encouraged to make use of the Wellness and Recovery Centers groups, classes and activities. SDC is scheduling monthly group sessions for SDC participants to share recovery stories, resource information, and to provide mutual support. SDC conducts home visits as needed to ensure that individuals are assisted with pursuing their recovery goals and working on their plans. This year, the Network of Care is being explored as a resource as OCA, Inc. assists individuals with accessing benefits, with housing issues, and with developing advance directives as needed. Each person active in the OCA, Inc. programs (SDC, Peer Support and Advocacy, etc.) is provided a brochure of rights and responsibilities as well as a procedure for filing grievances.

Strategy Accomplishment:
This strategy was achieved.

Objective 1.3. MHA will increase opportunities for consumer, youth, family and advocacy organizational input into the planning, policy, quality assurance, evaluation, and decision-making processes.

(1-3A)
Participate in oversight of the Consumer Quality Team (CQT) project and plan for statewide expansion.
Indicators:
- Psychosocial programs and inpatient facilities in Maryland visited
- Continued expansion into counties, covering Maryland's most populous regions and outlying jurisdictions
- Survey initiated on proposed changes to inpatient units
- Involvement with Smoking Cessation Project; observation of smoking behavior in proximity to programs
- Feedback meetings held, identified issues resolved, annual report submitted

Involved Parties: Clarissa Netter, MHA Office of Consumer Affairs; MHA Office of Planning and Training; state facility representatives; CSAs; MHAMD; NAMI MD; OOOMD; Community Behavioral Health Association of Maryland (CBH)
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Consumer Quality Team (CQT) initiative, which allows consumers and family members to play a direct role in the improvement of mental health services by recording and addressing individual consumers' satisfaction with the services, entered its fifth year in FY 2012. CQT facilitated a total of 300 site visits to Psychiatric Rehabilitative Programs (PRPs) and inpatient facilities. CQT interviewed a total of 1,186 consumers, reporting the finding to the facility/program director, the CSA, and MHA leadership. The project continues to protect and enhance rights by obtaining first hand information from consumers about their experiences in programs and takes an active role in addressing issues right at the program level and, as needed, at other system levels. Both consumers and program staff have reported significant program changes made as a result of the reports.

In addition to the above routine activities, CQT continued the project to track the 63 consumers who were discharged as a result of the closure of the Upper Shore Hospital Center. In FY 2012, 57 of the 63 individuals who were interviewed, either in-person or by phone, gave evidence of successful relocations. As a result of this project, CQT expanded its activities into six programs in several jurisdictions on the Eastern Shore. Other major activities of the CQT in FY 2012 included sharing results and lessons learned at national and local mental health conferences. The CQT provided 141.5 training hours, including Mental Health First Aid, Forensic Training at Eastern Shore Hospital Center (ESHC), Safety Training at Spring Grove Hospital Center (SGHC), On Our Own of Maryland (OOOMD) Conference; as well as on-going weekly sessions of interview reviews, reports, and improvement techniques. In working with various committees, projects, and councils, CQT has been instrumental in the development of the Peer Employment Specialist Toolkit and the curriculum for the Maryland Peer Support Specialist Certification Program.

As funding becomes available, the ultimate goal is to offer this initiative in all 24 jurisdictions and the remaining state-operated facilities.

Strategy Accomplishment:
This strategy was achieved.

(1-3B)
Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health (MCF) Family Leadership Institute for parents of children with emotional disorders; youth leadership programs; and the Leadership Empowerment and Advocacy Project (LEAP).
Indicators:
- Annual MCF Family Leadership Institute (FLI) convened, training activities for families implemented, number of graduates
- Increased youth leadership participation in state and local policy committees and public awareness events
- LEAP redefined and expanded to include increased collaboration with youth and young adult leadership and participation at statewide trainings
- Increased consumer and family participation in Public Mental Health System (PMHS) state and local policy planning

Involved Parties: Al Zachik and Tom Merrick, MHA Office of Child and Adolescent Services; Clarissa Netter and Susan Kadis, MHA Office of Consumer Affairs; CSAs; OOOMD; MCF; Youth MOVE and other youth leadership

MHA Monitors: Al Zachik, MHA Office of Child and Adolescent Services and Clarissa Netter, MHA Office of Consumer Affairs

FY 2012 activities and status as of 6/30/2012 (end-year report):
Family Leadership Institute
The Maryland Coalition of Families for Children's Mental Health (MCF) held its sixth Family Leadership Institute (FLI) in FY 2012 to train families to advocate for their children and all of Maryland's children in their communities and across the state. In 2012, participant selection was very competitive. Twenty-two individuals completed all six sessions; among them were four couples. In addition there were seven participants who are active duty, retired military, or military spouses.

The FLI graduated 23 participants from 13 jurisdictions, increasing the total number of trained family advocates to 115 over the five years of the Institute's implementation. The sessions included Friday nights so that attendees were able to develop relationships with the presenters, organizations representatives, and each other. Participants will hopefully use those connections to further advocate for their families and for increased resources in the community.

As a result of the efforts over the years with FLI, there has been robust family, youth, and consumer involvement in the major policy movement toward behavioral health integration and Medicaid reform currently in process in Maryland.

Youth MOVE
Youth Motivating Others through Voices of Experience (Youth MOVE) is a national program that unites the voices and causes of youth and helps them become more involved in the politics and legislation of mental health policies. Some Maryland jurisdictions have been able to create a youth-driven presence on the various system levels. The youth leadership steering committee met in March 2012. This initial event was an organizational meeting related to youth and young adult empowerment. Staff for this committee were hired by OOOMD and MCF.

LEAP
The Consumer Affairs Liaison within the MHA Office of Consumer Affairs (OCA) is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP) which has been funded by the MHA since 1990. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates while playing a prominent role within state and local policy-making bodies. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state.

In FY 2012, LEAP training took place during four sessions in April and May. The participants participated in workshops in the areas of recovery, assertiveness training, leadership skills, cross-disability advocacy, and the future of services under Medicaid. Twenty-five participants from across the state graduated from the program in FY 2012. LEAP graduates continue to serve on committees, federal and state advisory boards; as well as participate in the state planning process for the Public Mental Health System.

Strategy Accomplishment:
This strategy was achieved.

GOAL II. PROMOTE A SYSTEM OF INTEGRATED CARE WHERE PREVENTION OF SUBSTANCE ABUSE AND MENTAL ILLNESS IS COMMON PRACTICE ACROSS THE LIFE SPAN.

Objective 2.1. MHA, in collaboration with CSAs, the administrative services organization (ASO), managed care organizations (MCOs), behavioral health and health care providers, and other administrations and agencies, will continue to develop mechanisms to promote integrated health care.

(2-1A)
Continue to facilitate coordination of care activities throughout the Public Mental Health System (PMHS) and study data to determine impact of wellness activities and coordination of care in the provision of community mental health services.
Indicators:
- Utilization of existing interagency data to facilitate coordination of care i.e. pharmacy data (PharmaConnect)
- Collaboration with Medicaid Pharmacy regarding prescribing practices of anti-psychotic medicine in children
- Utilization of the Coordination of Care Committee to coordinate care of complex dual diagnosis cases
- Monitoring of utilization of resilience and recovery practices in treatment plans in community programs
- Increased access to registered public health providers through the administrative services organization (ASO) Web site, compliance activities monitored, and coordination of care activities administered through monthly meetings of medical directors of MHA and HealthChoice
- System integration of elements of coordination of care in PMHS through the Community Mental Health Medical Directors Consortium

Involved Parties: Gayle Jordan-Randolph and Jean Smith, MHA Office of the Clinical Director; Renata Henry, DHMH Deputy Secretary for Behavioral Health and Disabilities; MHA Office of Compliance and Risk Management; MHA-MCO Coordination of Care Committee; Community Mental Health Medical Directors Consortium; Alcohol and Drug Abuse Administration (ADAA); MCOs; Medical Assistance - Office of Health Services; ValueOptions®Maryland

MHA Monitor: Gayle Jordan-Randolph, MHA Office of the Clinical Director

FY 2012 activities and status as of 6/30/2012 (end-year report):
Indicator #2 is addressed in Strategy # 2-1B below.

MHA continues to monitor data, develop wellness activities, and facilitate coordination of care throughout the system. MHA is collaborating with the MHA-MCO Coordination of Care Committee, through monthly meetings, to determine barriers and strategies for integrated care and to identify universal outcomes. Also, data mining continues within the Medicaid (MA) Pharmacy system to identify utilization patterns.

Additionally, MHA is collaborating with DHMH's Prevention and Health Promotion Administration to identify behavioral health strategies to improve HIV/AIDS identification, tracking, and adherence to wellness strategies.

Strategy Accomplishment:
This strategy was achieved.

(2-1B)
In collaboration with the University of Maryland's Research, Education and Clinical Center, the Maryland Child and Adolescent Mental Health Institute, and the University of Maryland School of Pharmacy, implement practice guidelines to ensure appropriate pharmacological utilization for adolescents and children with serious mental illness or serious emotional disorder with focus on youth in Baltimore foster care system and for Medicaid recipients under age five across the state.

Indicator:
- Pharmacological practice guidelines defined
- Report on implementation of practice guidelines completed
- Number of cases reviewed

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; other MHA staff; Maryland Medical Programs (DHMH); the University of Maryland, Community Psychiatry Division; the Maryland Child and Adolescent Mental Health Institute; the University of Maryland; University of Maryland School of Pharmacy; Department of Human Resources (DHR); CSAs; Maryland Department of Juvenile Services (DJS); the Maryland State Department of Education (MSDE); NAMI MD; OOOMD; MCF; Community Behavioral Health Association of Maryland (CBH); and other interested parties

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
In FY 2010, a project to address the concern about appropriate use of psycho-pharmacological medication for children and adolescents, especially those in out-of-home placements, was developed and put into effect in collaboration with the Johns Hopkins University School of Medicine and the University of Maryland. A Psychopharmacology Learning Collaborative, consisting of psychiatrists who provide services to youth in the juvenile justice system, was formed to examine the use and administration of psychotropic medication to youth in custody. Through the University of Maryland Department of Psychiatry, Innovation Institute, a peer review process was put in place during FY 2012 to address circumstances when inappropriate prescribing practices are found and to notify physicians that such prescribing is not considered within the normally acceptable range of practice.

The clinical review criteria have been developed with input from MHA, Medicaid, DHR, MCF, and health experts in the area of child psychiatry, pharmacology, pediatric endocrinology, and psychology. The pre-authorization process started in October 2011 for Medicaid insured youth age five years and under and expanded during Phase two of

the program to include children less than 10 years of age on July 31, 2012. Considerable time was spent updating criteria to reflect additional diagnoses in older children, gathering data to coordinate with other programs, and providing outreach. The program includes more than 1,600 clients, 500 prescribers, and 600 pharmacies.

Approximately 59 children, less than age five, were on antipsychotics at the start of the program. Approximately, 60% of the children were approved to continue to receive antipsychotic medications. Of the remaining children, most were voluntarily discontinued by their prescribers. About one-third of the prescribers were primary providers including pediatricians, nurse practitioners, and family practitioners. The summary report in its entirety was forwarded to MHA and the Baltimore City Department of Social Services (DSS).

In addition, this project continues to analyze and link psychotropic medication usage with the DSS Chessie data and Maryland public health and pharmacy claims data for youth in the Baltimore City DSS out of home placement. The most current report looks at psychotropic medication use from January 2011 – December 2011 for specific age groups. Based on the data, notable results included the trend that, in children aged 0-4, Attention Deficit Hyperactivity Disorder medication use increased over time; in children aged 5-9, mood stabilizer and antidepressant use tends to remain consistent over time.

The program is in the process of contacting prescribers for children who are currently receiving antipsychotics according to Medicaid Pharmacy Program records. This group is hosting a meeting with a national expert from the University of Illinois, Chicago, on psychotropic medication usage in child welfare on September 21 and September 22, 2012.

<u>Strategy Accomplishment:</u>
This strategy was achieved.

(2-1C)   *Federal Mental Health Block Grant*

Collaborate with the MDQuit Center of the University of Maryland – Baltimore County (UMBC), consumers, providers, private partnerships, and other behavioral health stakeholders to promote and implement smoking cessation initiatives for all individuals served by the Public Mental Health System to reduce mortality rates.

Indicators:
- Utilization of results of Substance Abuse and Mental Health Services Administration (SAMHSA) Policy Academy for Maryland on Wellness and Smoking Cessation to develop and implement Statewide Plan in conjunction with the Alcohol and Drug Abuse Administration (ADAA), providers, CSAs, and consumers
- Guidance and technical assistance provided to CSAs on successful smoking cessation initiatives (such as two models implemented at Silver Spring Wellness and Recovery Center and at Lower Shore Friends, Inc.)
- Increased awareness, promotion of public education, and raised consciousness of the essential role of smoking cessation in overall wellness through multiple media sources, as well as shared information gained through the state's Outcome Measurement System survey
- Smoking cessation resources added to Network of Care (NOC)
- Collaboration with the MDQuit Center in the development of tools for ongoing evaluation of the effectiveness of smoking cessation efforts

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; MHA Office of Adult Services; MHA Office of Child and Adolescent Services; other MHA staff; MHA Consultants; Alcohol and Drug Abuse Administration (ADAA); MCOs, MA HealthChoice; CSAs; UMBC MDQuit Center; Community Behavioral Health Association (CBH); On Our Own of Maryland (OOOMD); Mental Health Association of Maryland (MHAMD); MCF

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; MHA Office of Adult Services; MHA Office of Child and Adolescent Services; other MHA staff; MHA Consultants; DHMH; ADAA; MCOs, MA HealthChoice; CSAs; UMBC's MDQuit Center; CBH; On Our Own of Maryland (OOOMD); Mental Health Association of Maryland (MHAMD); MCF; Arundel Lodge; Uniformed Services University of the Health Sciences

FY 2012 activities and status as of 6/30/2012 (end-year report):
Maryland was one of only a half-dozen states selected by SAMHSA to participate in a Leadership Academy for Wellness and Smoking Cessation Summit. Four workgroups – Consumer Issues; Staff Tobacco Use; Education and Training; and Legislative and Policy Issues – were established to pursue the goals developed for the state at the policy academy. The Staff Tobacco Use Workgroup and the Education & Training Workgroup collaborated on the development of a survey designed to measure and assess clinical and support staff tobacco/smoking behavior at mental health provider agencies across Maryland. The primary goal of the survey is to design effective interventions and extensive educational materials to assist mental health provider staff break free of tobacco and take a more active role in assisting mental health consumers to do the same. The survey was finalized at the end of June 2012 and administration is planned for late

summer/early fall of 2012. Based on the survey, the target date for a report and recommendations toward development of a statewide Plan is December 31, 2012.

Tobacco Cessation questionnaire data is captured through MHA's Outcomes Measurement System (OMS). Additionally, MHA worked with DHMH's Center for Health Promotion, Education & Tobacco Use Prevention, and ADAA to develop metrics for monthly StateStat submissions to measure: the number of adults and youth with behavioral health issues who are smoking; number of calls to the Maryland Tobacco Quitline; and number of nicotine replacement therapy materials distributed.

The addition of smoking cessation resources to the Network of Care (NOC), to promote easier access to consumers and family members, is one of the goals of the Consumer Issues Workgroup (from the policy academy) and will be achieved in collaboration with the other three workgroups sometime in FY 2013. The results of the clinical and staff survey will play a pivotal role in the development of materials for the NOC.

The Tobacco Cessation Committee provides Technical Assistance (TA) and guidance on multiple cessation strategies to the CSAs through MACSA. The Tobacco Cessation Workgroup on Consumer Issues is facilitating the establishment of community linkages between the CSAs and local Wellness & Recovery Centers. Through a vigorous community education project, awareness of the dangers of small, candy-flavored cigars for youth has been promoted across the State. MHA continues its collaborations with the Maryland QUIT Center of UMBC, which offers consultation to community providers on utilization of toolkits, and TA is available to CSAs upon request.

A smoking cessation video, developed by one of the leading consumer groups in Maryland (Lower Shore Friends), was featured at the annual Mental Hygiene Administration Conference. Copies of the video were distributed to mental health providers, consumer organizations, advocates, and local government staff across the state as part of a wellness promotion effort.

Strategy Accomplishment:
This strategy was achieved.

(2-1D)   *Federal Mental Health Block Grant*
Implement the provisions of the Children's Health Insurance Program Reauthorization
Act (CHIPRA) Quality Demonstration Grant from the Centers for Medicare and
Medicaid Services (CMS) to examine and refine Care Management Entity (CME)
approaches.
Indicator:
- A consistent model for family peer support established
- Financing approach identified for populations served by CMEs
- Expansion of population eligibility served by CMEs explored
- A crisis response and stabilization model identified
- Coordination of CME service recipients' somatic and oral health improved
  consistent with wellness and Early and Periodic Screening Diagnosis and Training
  (EPSDT) standards of care
- Completion of program planning tool
- Timely submission of data to Center for Health Care Strategies

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; the
        Maryland Child and Adolescent Mental Health Institute; the University of
        Maryland; Department of Juvenile Services (DJS); Department of Human
        Resources (DHR); CMS; MCF; CHCS; State of Georgia; State of Wyoming
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
Maryland's CHIPRA Quality Demonstration grant is the only behavioral health grant,
among all those awarded by CMS, that focuses on the implementation, expansion, and
sustainability of Care Management Entities (CMEs) with continuing exploration of
growth of the CME structure for home and community-based services. This is a five year
grant, currently at the mid-point of implementation.

A proposed submission of a 1915(i) state Medicaid plan amendment has been developed
to redesign the program and the financing of CME Wraparound intervention. Changes
would expand the eligibility for CME enrollment. The draft is currently being considered
for submission.

Work on redesigning the family peer support model has continued. The Maryland
Coalition of Families for Children's Mental Health (MCF) organized focus groups and a
survey on somatic behavioral coordination topics related to physical health/oral
health/obesity and issued a report on the findings, which has already been utilized in
multiple presentations and discussions in Maryland. MCF has also been contracted to
provide education and support about access to somatic and dental care for families
enrolled in CMEs.

The Institute for Innovation and Implementation is in the process of developing new tools
for use in the peer support certification process, as well as an enhanced certification
model. Additionally, the Wraparound Practitioner Certificate program is being modified
to strengthen care managers ability to bridge somatic and behavioral health needs of
CME enrollees. The findings from MCF's focus groups and survey have helped to
inform the Wraparound Practitioner Certificate Program, which is required of the peer
support partners.

All of the CHIPRA Quality Demonstration Grantees participated in the first CMS quality Conference in August 2011 in Baltimore. A series of Webinars on various topics related to Care Management Entities was presented.

Strategy Accomplishment:
This strategy was achieved.

(2-1E)
Continue to interface and maintain liaison efforts and partnerships with other agencies and administrations to support a comprehensive system of behavioral and somatic health services and community supports.
Indicators:
- Collaborations established and implemented with the following state entities:

- **Maryland Department of Disabilities (MDOD)**, Brian Hepburn, Liaison – MHA continues to collaborate with MDOD in the development and implementation of cross-agency initiatives such as Money Follows the Person, transition-age youth projects, and the identification of action steps to promote affordable housing efforts. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Governor's Office for Children (GOC)/Children's Cabinet,** Albert Zachik, Tom Merrick, and Marcia Andersen, Liaisons – GOC and MHA are active partners in implementing the Wraparound and Psychiatric Residential Treatment Facility (PRTF) Waiver initiative for Maryland. As an active participant of the Children's Cabinet, MHA meets regularly with senior staff from the participating child-serving agencies to plan services across agencies for children, youth, and families. The Children's Cabinet Interagency Plan is monitored each year and intersects with MHA's ongoing planning processes.
- **Governor's Office of Deaf and Hard of Hearing (ODHH),** Marian Bland, Liaison – MHA's Director of the Office of Special Needs Populations served as DHMH's representative on the Maryland Advisory Council for Deaf and Hard of Hearing and participated in the behavioral health subcommittee meetings. MHA provided departmental updates on behavioral health integration and participated in the development of a statewide interpreting contract.
- **Maryland State Department of Education (MSDE),** Albert Zachik and Cyntrice Bellamy, Liaisons – MHA meets with the Assistant Superintendent for Special Education at MSDE to collaborate on mutual concerns involving the mental health needs of children in school and early childhood settings. Collaborative efforts continue regarding the Maryland Mental Health Workforce Initiative. This department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Division of Rehabilitation Services (DORS),** James Chambers and Steve Reeder, Liaisons – Joint efforts included implementation of the evidence-based practice model of supported employment (SE) and the dissemination of shared data and outcomes. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Department of Human Resources (DHR)**, Marian Bland, and Albert Zachik, Liaisons – MHA collaborated with DHR for input on Senate Bill 556 legislative mandate (re: increased safety at state facilities) two system of care grants, and to locally implement the state's Supplemental Social Security, Outreach, Access, and Recovery (SOAR) program and supportive services match for Shelter Plus Care grants. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Department of Housing and Community Development (DHCD)**, Penny Scrivens and Marian Bland, Liaisons –MHA coordinates with DHCD to facilitate applications for funding through the Housing and Urban Development (HUD) Continuum of Care. MHA participates on DCHD's applicant review panel for agencies seeking emergency and transitional funding. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland Department on Aging (MDoA),** James Chambers and Marge Mulcare, Liaisons – MHA provides training and consultation in fostering interagency connections between the local areas on aging and the CSAs; specifically in identifying older adult participants eligible to receive services through the PMHS. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Department of Public Safety and Correctional Services (DPSCS),** Larry Fitch and Marian Bland, Liaisons – MHA liaisons with DPSCS regarding individuals who require civil certification to MHA facilities, who hold the status of mandatory release, and/or who present complex cases. The Director of MHA Office of Forensic Services (OFS) co-chairs the quarterly meetings of the Interagency Forensic Services Committee of the Maryland Advisory Council on Mental Hygiene/Planning Council.

- **Department of Juvenile Services (DJS**), Albert Zachik, Cyntrice Bellamy, Eric English, and Larry Fitch, Liaisons – MHA's Office of Child and Adolescent Services: meets regularly with the Behavioral Health Director of DJS to plan mental health services; oversees behavioral health programs for youth in the juvenile justice system; and works in consultation with both DJS and MSDE on initiatives involving children's mental health. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland Department of Veterans' Affairs (MDVA)/Maryland National Guard (MNG),** Marian Bland, Liaison – MHA collaborates with representatives of the U.S. Department of Veterans Affairs, the Maryland Department of Veterans Affairs, the Maryland National Guard, and the Maryland Defense Force to promote services. MHA participates in the Veterans Behavioral Health Advisory Board through the Children, Family, and Special Populations subcommittee and with SAMHSA's Academy on Service Members, Veterans, and their Families. MHA maintains the Network of Care Web site for veterans and service members and also assists with implementing the SOAR initiative for veterans.

- **Judiciary of Maryland**, Larry Fitch, Liaison – The MHA Office of Forensic Services (OFS) collaborates with the judges of the Baltimore City District Court, the Prince George's County Mental Health Court, and other courts throughout the state on a variety of issues including the establishment of community-based mental health alternatives to incarceration for individuals evaluated at MHA facilities.

- **DHMH Alcohol and Drug Abuse Administration (ADAA),** MHA collaborates under the auspices of DHMH's Behavioral Health and Disabilities with ADAA in the ongoing efforts of Behavioral Health Integration. Partnerships were enhanced in planning MHA's Annual Conference and the state Mental Health Plan Development Meeting. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **DHMH Prevention and Health Promotion Administration [formerly Family Health Administration and Environmental Health and Infectious Disease Administration**], Al Zachik, Marian Bland and Darren McGregor, Liaisons – MHA collaborates on Maryland's implementation of the Nurse-Family Partnership® (an evidence-based, nurse home visiting program for low-income, first-time parents and their children) and works closely with the administration on the Early Childhood Mental Health. MHA participates on the HIV Community Planning Group along with Prevention and Health Promotion and ADAA to develop strategies to reduce risk of HIV infection. The group identifies populations with potential higher risks including individuals with mental illness and justice-involved individuals.

- **DHMH Developmental Disabilities Administration (DDA),** Stefani O'Dea and Lisa Hovermale, Liaisons –MHA/ DDA/ ADAA bi-weekly clinical and leadership meetings continue as well as meetings between DDA staff, state hospital staff, (and on request, with community-based PMHS providers. Also, OFS Staff communicate weekly with DDA to assist in evaluating court-involved individuals. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland Health Care Commission (MHCC)**, Brian Hepburn, Liaison – MHA collaborates with MHCC on health policy studies involving mental health services, reimbursement rates for hospitals, and issues involving health insurance coverage and the uninsured population.

- **Health Services Cost Review Commission (HSCRC)**, Brian Hepburn, Liaison – MHA and HSCRC meet periodically to update and Liaison the rate-setting process for hospital rates for inpatient services.

- **DHMH Health Care Financing/Medical Assistance,** Brian Hepburn, Gayle Jordan-Randolph, and Daryl Plevy, Liaisons – MHA participates in the Maryland Medicaid (MA) Advisory Committee and in the Medical Care Organizations' (MCOs) monthly medical directors meetings. MHA works with Maryland's Medical Assistance program on issues and state plan amendments such as Money Follows the Person, the 1915(i) Waiver for psychiatric rehabilitation services, telemental health services, and the Medicaid Emergency Psychiatric Demonstration. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **DHMH Office of Health Care Quality (OHCQ),** Audrey Chase and Sharon Ohlhaver, Liaisons – MHA collaborates with OHCQ in relation to regulatory and compliance meetings and activities. In addition, MHA and OHCQ have both participated in a Behavioral Health Regulations Integration Workgroup during the year. Program-specific issues and issues related to regulatory interpretation and compliance continue to be discussed and addressed.

- **DHMH Office of Capital Planning, Budgeting, and Engineering Services,**
Cynthia Petion and Robin Poponne, Liaisons – MHA, in collaboration with this Office, processes requests for the DHMH Administration-Sponsored Capital Program (Community Bond) which provides capital grant funds for prioritized community-based services such as the development of affordable housing for individuals with serious mental illnesses (SMI).

- **Maryland Emergency Management Administration (MEMA),** Gail Wowk, Liaison – MHA continues its partnership with MEMA (the state agency responsible for mass care and shelter), DHMH's Office of Preparedness and Response, MDOD, and DHR. Ongoing trainings and presentations are offered to state facilities and involved state agencies.

Strategy Accomplishment:
This strategy was achieved.

Objective 2.2. MHA will work with the CSAs and other stakeholders to develop, implement, and evaluate screening, prevention, and early intervention services across the life span for individuals with psychiatric disorders or individuals who are at risk for psychiatric disorders.

(2-2A)
In collaboration with the Maryland Child Adolescent Mental Health Institute, the Maryland State Department of Education (MSDE), the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders continue to build infrastructure and deliver training to improve the quality of mental health screening assessment and intervention for young children.
Indicators:
- University of Maryland Early Childhood Mental Health Certificate program expanded to Bachelor's level participants – An additional 20 professionals trained
- The Maryland implementation of the Nurse-Family Partnership® (an evidence-based, nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children)
- Summary of implementation data from the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) reviewed

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; MSDE; Center for Maternal and Child Health; the Maryland Blueprint Committee
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
The purpose of the Early Childhood Mental Health (ECMH) Certificate Program is to offer specialized training to clinicians in core knowledge, skills, and attitudes necessary for practicing in the field of early childhood mental health. The University of Maryland Early Childhood Mental Health Certificate program expanded to Bachelor's level participants with an additional 20 professionals trained at the end of FY 2012. The University of Maryland Center for Infant Study provided instruction to 27 participants. With the conclusion of the FY 2012 course ending on November 18, 2011, 147 participants have now participated in the University of Maryland's Early Childhood certificate program since its beginning. Participants were both bachelors and masters

level prepared and represented a variety of disciplines including child care, mental health, and education. The next cohort is scheduled to begin in October 2012

Maryland has implemented the Nurse-Family Partnership® (NFP), an evidence-based, nurse home visiting program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. NFP has been added to the Baltimore City evidence-based home visiting programs. The focus of NFP is first-time teen Moms. Baltimore City has identified this group as one of the high risk populations in need of additional parenting support. The program can serve up to 100 mothers. Full implementation of NFP began in May 2012 and currently 25 families are being seen through this program.

The Governor's Office for Children (GOC) (on behalf of the Children's Cabinet) and DHMH/Center for Maternal and Child Health (CMCH) have collaborated to administer all Maryland's Home Visiting Programs as part of federal funding made available through the Affordable Care Act and Maryland has been allocated $1 million for five years beginning in FY 2010.

Maryland, through Center on the Social and Emotional Foundations for Early Learning (CSEFEL) and MSDE, is participating in a training and technical assistance project to foster the professional development of the early care and education workforce. CSEFEL has been aligned with: Early Childhood Mental Health (ECMH) Standards of Practice, ECMH Certificate Program, ECMH Core Competencies, and Social and Emotional Learning Parties developed by Ready at Five Partnership. Currently, 20/24 local school systems have accessed Maryland Model for School Readiness funding (since 2007) to train local school system early childhood staff and early childhood community partner staff (Head Start, child care, etc) on CSEFEL implementation.

For the 2012-2013 school year the following counties plan to expand their Maryland's CSEFEL initiative:
- Caroline, Cecil, Howard, Kent, Queen Anne's, Prince George's counties and the Maryland School for the Deaf have accessed a portion of their Maryland Model for School Readiness (MMSR) Grant Funding to continue to support their on-going CSEFEL implementation projects by providing either continued training on implementation or coaching, or external coaching to support existing CSEFEL classrooms.
- Charles, Dorchester, Frederick, Somerset, St. Mary's and Wicomico counties have identified MMSR funding to begin CSEFEL implementation in their local school systems, including early childhood community partners.

Strategy Accomplishment:
This strategy was partially achieved.

(2-2B)

MHA will work in conjunction with Department of Human Resources (DHR), Care Management Entities (CMEs), and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.

Indicators:

- CME data reported on child welfare populations served
- Systems of Care grants - MD CARES and RURAL CARES – implemented in Baltimore City and nine Eastern Shore counties
- Mobile Crisis Stabilization Service Initiative continued for children placed in foster care settings

Involved Parties: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services; the Maryland Child and Adolescent Mental Health Institute; DHR; MCF; CSAs; local Department of Social Services (DSS) offices

MHA Monitors: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
MD CARES and Rural CARES

Funded through two SAMHSA System of Care (SOC) grants for youth in the child welfare system in Baltimore and the Eastern Shore counties of Maryland, MD CARES and Rural CARES projects have been implemented to expand and support "wraparound" services to foster children in specific communities. MD CARES in Baltimore City served approximately 34 youth in FY 2012 and Rural CARES served approximately 60. Utilization data on these grants are included in MHA StateStat reporting and are available for summary on a monthly basis.

Care management is provided for youth placed at the group home level by both DHR and DJS and for youth under the provision of the two SOC grants. Contracts have been awarded to two private vendors to deliver the service of interagency Care Management Entities (CMEs) statewide and the CMEs continue to provide services to youth in foster care within their respective jurisdiction. Through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant, Maryland is actively involved in a major sustainability project to maintain and expand the CME infrastructure.

Maryland's Crisis Response and Stabilization Service
Maryland's Crisis Response and Stabilization Service Initiative provides 24/7 crisis services to youth in foster care within 13 jurisdictions. This service helps respond to children in kinship care as well as in-home and foster care placements to intervene in the home setting so that psychiatric crises and resulting hospitalizations do not result in the disruption of the child's residential placement. The programs within the jurisdictions operate as a mobile crisis program which is available 24 hours daily. Some services added by jurisdictions include individual therapy, respite, and assistance with voluntary placement cases. However, further expansion of this project has been curtailed due to budget limitations. To date, eleven of the jurisdictions where this service is available have met or exceeded the expectations of the program. Anecdotal summaries are collected and submitted to MHA.

Strategy Accomplishment:
This strategy was achieved.

(2-2C)
Mental Hygiene Administration will participate, in the Maryland State Department of Education's (MSDE's) strategic planning process to identify strengths and needs of school health programs and councils statewide.
Indicators:
- Committee convened; input gathered from external and internal stakeholders
- Strengths and needs assessed to develop recommendations to enhance school health programs statewide

Involved Parties: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services; MSDE; Maryland State School Health Council; the University of Maryland Center for School Mental Health; MCF; local school systems; private providers

MHA Monitors: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
In FY 2011, Mental Hygiene Administration staff participated in the workgroups of the Steering Committee on Students with Emotional Disabilities. Strengths and needs were assessed and recommendations were made by the committee in the areas of staff training and technical assistance, anti-stigma labeling, and changes in individualized education program development. The Committee completed its report. However, work continues through the recently restructured Education Mental Health Leadership Committee.

Mental Hygiene Administration continues to serve as a consultant, when needed, with Maryland State Department of Education to address the mental health needs of children within the school system.

Strategy Accomplishment:
This strategy was achieved.

(2-2D)
MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.
Indicators:
- Continued monitoring of utilization of Youth Suicide Hotlines for increased access
- DHMH/MHA participation in the Governor's Commission on Suicide Prevention and workgroups established to focus on issues of various populations
- Interim Commission report submitted
- Plan developed for suicide prevention across the life span

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Renata Henry, DHMH Deputy Director of Behavioral Health and Disabilities; Governor's Office for Children (GOC); Al Zachik and Henry Westray, MHA Office of Child and Adolescent Services; Cynthia Petion, MHA Office of Planning and Training; James Chambers, MHA Office of Adult Services; Maryland Department on Aging; Youth Crisis Hotline Network; the Maryland Committee on Youth Suicide Prevention; Wellness and Recovery Centers; MSDE; CSAs; Johns Hopkins University; University of Maryland; local school systems; other key stakeholders

MHA Monitors: Al Zachik, MHA Office of Child and Adolescent Services and Cynthia Petion, MHA Office of Planning and Training

FY 2012 activities and status as of 6/30/2012 (end-year report):
In October 2009, Maryland's Governor O'Malley signed an Executive Order to create the Maryland Commission on Suicide Prevention. The 21-member commission is comprised of members from various state departments, the Legislature, advocacy organizations, along with a suicide survivor and a family member of an individual who completed suicide. The Commission is charged with the development of a comprehensive, coordinated, strategic plan for suicide prevention, intervention, and post-vention services across the state. The Commission convened three workgroups, to focus on the following areas: Public Awareness, Prevention/Intervention, and Post-vention. Each workgroup was charged with discussing overarching strategies that:

- Advance the science of suicide prevention
    - Test, replicate and utilize new strategies (promising and evidence-based practice pilot sites) as appropriate throughout the state
- Support MHA's Mission and Values statements that reflect concern for all persons with mental illness of all ages, supporting a consumers' right to access appropriate mental health services in all suicide prevention, intervention, and post-vention efforts
- Develop more coordinated prevention, intervention, and post-vention services across the state for all ages.

Strategies to be included in the plan might also be specified to a special high-risk population(s) such as veterans or lesbian, gay, bi-sexual, transgender, or questioning (LGBTQ); as well as populations across the lifespan.

The Suicide Commission workgroups finalized their work in the spring 2012 and submitted their recommendations for next steps to the Commission. The Commission is currently working on the final plan to the Governor to be submitted in the fall of FY 2013.

Additionally, the Maryland Youth Crisis Hotline Centers, between July 1, 2011 and June 30, 2012, answered 7,464 calls. Each call center reports caller data to the Johns Hopkins grant team on a quarterly basis. The Hotline monitoring is continuous. Also, there is continued enhancement of efforts of Crisis Response Teams to follow-up with youth identified as at-risk for suicide. The Commission recommends the Hotline be entitled, Maryland Crisis Hotline, this will welcome calls from persons in crisis across the life span.

Strategy Accomplishment:
This strategy was achieved.

Objective 2.3. MHA, in collaboration with the CSAs and other stakeholders, will continue to facilitate the development, implementation, and evaluation of services that address the needs of children, adolescents, transition-age youth with psychiatric disorders, and their families.

(2-3A)
MHA, in collaboration with Maryland Department of Disabilities (MDOD), Department of Human Resources (DHR), Maryland State Department of Education (MSDE), and other stakeholders, will develop integrated home and community-based services and supports for youth and young adults in transition through the Healthy Transitions Initiative demonstration project in Washington and Frederick counties.
Indicators:
  • Seamless referral protocols established to link youth-serving agencies with the Public Mental Health System (PMHS) for services to transition-age youth
  • Involved systems and services identified and eligibility criteria reviewed
  • 67 youth and young adults in transition served
Involved Parties: Tom Merrick, MHA Office of Child and Adolescent Services; Steve Reeder, MHA Office of Adult Services; MDOD; MSDE; CSAs; DHR; MCF; Youth Motivating Others through Voices of Experience (Youth MOVE) and other youth leadership; Governor's Interagency Transition Council for Youth with Disabilities; Maryland's Ready by 21; the University of Maryland; local school systems; parents; students; advocates; other key stakeholders
MHA Monitors: Tom Merrick, MHA Office of Child and Adolescent Services and Steve Reeder, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Healthy Transitions Initiative (HTI) demonstration project develops and provides integrated home and community-based services and supports for Transition-Age Youth through the pilot program in Washington and Frederick Counties. HTI programs are established, fully staffed, and actively collaborating with community organizations and leaders to increase community capacity to address transition issues in each site. The contracted provider of services, Way Station Inc., collaborates with MHA, HTI leadership, and community organizations to provide transition services to youth, young adults, and parents/caregivers in both counties. The project is entering year four of its five-year funding period and has served 94 youth and young adults during FY 2012.

HTI has developed referral protocols, static strategic and operational plans which align with relevant state and federal transition-related efforts. Through the Project Leadership Team, local coordinating councils, and State Advisory Committee meetings, the plans are updated, monitored for efficacy, and adjusted as needed.

HTI employs the Transition to Independence Process (TIP) model with a combination of a team of transition facilitators and expanded access for youth to both evidence-based supported employment and assertive community treatment (ACT), if needed. Mutually beneficial partnerships have been established with Maryland-based chapters of NAMI, MCF, On Our Own, and Youth MOVE. Local Implementation Committees have been established in Frederick and Washington counties to further address such issues while the

HTI State Advisory Committee actively addresses state level collaboration and alignment with broader scoping state plans.

Maryland HTI collaborates with the University of Maryland's Innovations/Children's Mental Health Institute & Evidence-Based Practice Center to provide local evaluation for the Healthy Transitions Initiative demonstration project in Washington and Frederick Counties. Additionally, HTI is coordinating with two federal consultants, ICF Macro and SAMHSA, to participate in the seven state cross-site evaluation.

HTI continues to facilitate training and educational events on local, state, and national levels to increase awareness and understanding of transition –
related issues of youth and young adults with mental health disorders.

Strategy Accomplishment:
This strategy was achieved.

(2-3B)
MHA, in collaboration with other state agencies, will participate in Maryland's Commission on Autism to evaluate and increase understanding of services that address the needs of Maryland families with children and adults with Autism Spectrum Disorders.

Indicators:
- An interim report submitted with recommendations regarding health care, education, and other adult and adolescent services
- Research and training needs identified
- Interim plan developed to address an integrated system of training, treatment, and services for individuals of all ages with autism spectrum disorders

Involved Parties: Al Zachik, Marcia Andersen, and other staff – MHA Office of Child and Adolescent Services; Renata Henry, DHMH Office of the Deputy Secretary of Behavioral Health and Disabilities; Maryland Department of Disabilities (MDOD); MSDE; DHR; the Kennedy Krieger Institute; the University of Maryland; parents; students; advocates; other key stakeholders

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
On October 1, 2009, Governor O'Malley appointed the membership of the Maryland Commission on Autism to develop a comprehensive statewide plan for an integrated system of services, training, and treatment for persons with autism spectrum disorders; including a focus on health care, education, and adolescent and adult issues. The commission consists of 26 members, including the DHMH Deputy Secretary for Behavioral Health and Disabilities who serves as Chair, representatives from various state and consumer protection agencies, parents, schools, therapists, pediatricians, and advocates.

The Commission held its early meetings designated as "listening sessions" in four different parts of the state – western, central, southern, and eastern. These sessions included a panel of speakers as well as opportunities for public comment, which provided the Commission with insight into regional issues.

An interim plan was submitted in August, 2011 which addressed five themes: access, quality, communication, training, and funding. These themes assisted the Commission to envision what a comprehensive system of services and supports would include.

The Commission continues to conduct most of its work within seven workgroups established during its first year of operation (adult service system, evidence-based practice, funding and resources, health/medical services, research partnerships, transition age youth, and workforce development). A final report was submitted to the Governor and the Maryland General Assembly on September 30, 2012 with recommendations regarding health care, education, enhanced partnerships, transitioning to adulthood needs, and other adult and adolescent services. Some recommendations will address issues such as insurance coverage, improved information sharing and developmental screening, training, access to education opportunities, employment, statewide awareness and outreach, and evidence-based practices.

Strategy Accomplishment:
This strategy was achieved.

Objective 2.4. MHA will collaborate with CSAs and stakeholders to promote screening for mental health disorders, improve access and quality of PMHS services for individuals with co-occurring disorders, and provide linkages to appropriate treatment and supports across the life span.

(2-4A)   *Federal Mental Health Block Grant*
In collaboration with DHMH and ADAA, continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment.
Indicators:
- Continued support of the DHMH Supervisors' Academy for Co-occurring Disorders; included provision of training/coaching by the University of Maryland Evidence Based Practice Center's Consultant/Trainer on Co-Occurring Disorders
- Technical assistance (TA) provided to Core Service Agencies requesting assistance in promoting DDC within their jurisdictions
- Continued TA to the substance abuse specialists on Assertive Community Treatment (ACT) teams
- Ongoing training provided on the use of scientifically-validated screening and assessment instruments in support of screening for and assessment of co-occurring disorders

Involved parties: Carole Frank and Cynthia Petion, MHA Office of Planning and Training; James Chambers, MHA Office of Adult Services; Clarissa Netter, MHA Office of Consumer Affairs; Eileen Hansen and Tom Godwin, the University of Maryland Evidence Based Practice Center (EBPC); ACT teams; mental health providers
MHA Monitor: Carole Frank, MHA Office of Planning and Training

FY 2012 activities and status as of June 30, 2012 (end of year report):
A number of existing mental health treatment and rehabilitation programs, as well as programs established through ADAA, have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses.

MHA, in collaboration with ADAA and DDA, co-sponsored two (running concurrently) DHMH Supervisors' Academies for Co-occurring Disorders. One was for Eastern Shore participants and the other was for Western Maryland participants. Forty supervisors/trainers from all three administrations participated in this yearlong interdisciplinary, train-the-trainer program consisting of monthly day-long sessions.

Over the past couple of years, MHA has worked toward the implementation of a work plan designed to increase the number of programs that are DDC. Six county jurisdictions, Anne Arundel, Washington, Carroll, Mid Shore, Garrett and Worcester, have received TA to focus on the development of DDC. Since the focus of consultations are targeted toward screening and assessment for co-occurring disorder (COD), group treatment, and treatment matching and planning, it was found that a series of small group, skill-based trainings around COD competencies would be beneficial on an ongoing and more widespread basis. Trainings on screenings, assessments, and person centered care (an important practice for individuals with complex disorders that has been adopted within the Minkoff/Cline Comprehensive Continuous Integrated System of Care), were

conducted in FY 2012. These trainings are open to all three administrations upon request. During the FY 2012 round of training there were 225 attendees.

TA continued to be provided by the University of Maryland Evidence – Based Practice Center to substance use specialists on five separate ACT (Assertive Community Treatment) Teams - Johns Hopkins, Turning Point, Inc. in Washington County, Baltimore City ACT team at BonSecours, People Encouraging People, and Lower Shore Friends. Five day-long regional training sessions on screening and assessment instruments, including the new format, were conducted with about 30 attendees on each occasion.

Strategy Accomplishment:
This strategy was achieved.

(2-4B)
MHA and the University of Maryland Systems Evaluation Center (SEC) will analyze data relating to utilization of PMHS services by individuals with co-occurring disorders to further inform system and service planning and identify areas for quality improvement activities.
Indicators:
  - Analysis conducted of consistency between diagnosis and self or provider report upon initial authorization of services in the Outcomes Measurement System (OMS) population

Involved parties: SEC; University of Maryland Evidence Based Practice Center; Cynthia Petion, MHA Office of Planning and Training; Susan Bradley, MHA Office of Management Information System (MIS) and Data Analysis; ValueOptions®Maryland
MHA Monitors: Cynthia Petion, MHA Office of Planning and Training and Susan Bradley, MHA Office of MIS and Data Analysis

FY 2012 activities and status as of 06/30/12 (end-year report):
The Outcomes Measurement System (OMS), an interactive Web-based system, was reestablished with refinements in FY 2011. Additionally, the SEC has continued to refine the OMS Datamart, and focus on comparing and contrasting the OMS change-over-time data results for those consumers who have a co-occurring substance abuse disorder with results for those consumers who do not have a co-occurring substance abuse diagnosis. Results of these analyses were presented at the annual MHA Conference. Results indicated that individuals with co-occurring disorders are more likely to be: males; older; caucasian; homeless or in non-independent living situations; in jail or prison; arrested; unemployed; a cigarette smoker; and/or in poorer health in general.

These types of analyses will continue to be important as behavioral health integration moves forward.

Strategy Accomplishment:
This strategy was achieved.

(2-4C)   *Federal Mental Health Block Grant*
Create a system of integrated promotion, prevention, and treatment options for children, youth, and young adults who are at risk for, or have mental health and/or substance abuse disorders that include a strong focus on supporting their families and the communities where they live.

<u>Indicators</u>:
- The Institute of Medicine (IOM) prevention framework adopted
- ADAA prevention infrastructure further developed
- Mental health and substance abuse systems professionals cross-trained in co-occurring treatment best practices with recipients of behavioral health services and their families
- Policies, procedures and regulations reviewed across systems

<u>Involved Parties</u>: Al Zachik, MHA Office of Child and Adolescent Services; MHA Staff; ADAA; CSAs; Health Departments; providers; consumers; families; advocates

<u>MHA Monitor</u>: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
In the fall of 2011, SAMHSA awarded Maryland a one-year System of Care (SOC) Planning Grant for approximately $600,000 to help plan and support the development of an integrated behavioral health system of care for children, youth, and their families with mental health and substance use issues. The Maryland Behavioral Health Collaborative was established as a part of this grant to serve as an advisory committee to the planning effort. The initial Behavioral Health Strategic Plan of the grant has eight major goals. These goals include: wellness, screening and assessment, adequate service package, quality improvement, workforce development, policy planning, and social marketing.

A no-cost extension was awarded to the state for 12 additional months (until September 30, 2013) to further plan and develop a statewide SOC and assess training and workforce development needs to support the efforts related to the DHMH Behavioral Health Integration process.

Under the first year of this grant, in addition to the advisory committee, a Management Team was convened and sub-committees formed to develop work plans, which were used to develop the initial Behavioral Health Strategic Plan. A sub-committee on Wellness incorporated elements of the IOM prevention framework within its recommendations. Through efforts guided by the MHA Office of Child & Adolescent Services and the Alcohol and Drug Abuse Administration (ADAA), a process, aligned with DHMH (MHA-ADAA) Behavioral Health Integration, took place to gather stakeholder input, review regulations, and examine lessons learned from other states moving towards behavioral health integration.

Strategy Accomplishment:
This strategy was achieved.

Objective 2.5. MHA will closely monitor the activities of national and state health reform and prepare and plan appropriate coordination and collaboration.

(2-5A)
Improve communication, and efforts that support activities that lead to implementation of health reform and coordination of care, in the delivery of services to individuals with mental illnesses.

Indicator:
- Network of providers educated about Health Care Reform, through DHMH and MHA Web-sites, MHA conference, Webinars, and Community Mental Health Directors meetings
- Activities of community mental health providers who are integrating somatic care into their services monitored and supported

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Gayle Jordon-Randolph, MHA Office of the Clinical Director; Cynthia Petion, Office of Planning and Training; Melissa Schober, MHA Medicaid Policy Analyst; CSAs, Centers for Medicare and Medicaid Services (CMS); Medical Assistance or Medicaid (MA); other mental health consumer and family advocacy groups; CBH; other stakeholders

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordon-Randolph, MHA Office of the Clinical Director

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Maryland Health Care Reform Coordinating Council (HCRCC), established by Governor O'Malley in response to the enactment of the Patient Protection and Affordable Care Act (ACA) also known as Health Care Reform, issued a final report on January 1, 2011. Included Among several recommendations was recognition of the need for establishing a Health Benefit Exchange and improvement of coordination of behavioral health and somatic services. In April 2011 Governor O'Malley signed an executive order to establish the Governor's Office of Health Care Reform to continue the work toward implementing ACA.

In light of the passage of ACA, a kick-off session took place in March 2012 to initiate the process of choosing a new Medicaid financing structure and model that improves the integration of Medicaid-financed behavioral health. This process of selecting an integration model for Medicaid-financed behavioral health services is comprised of three phases.
- The first phase began back in 2011 and involved collaborative work between the Department, a consultant, and stakeholders in order to assess the strengths and weaknesses in Maryland's current system.
- Phase 2 of the process began in early 2012 as the Department and stakeholders set out to develop a broad financing model to better integrate care across the service domains. Between March and September 2012, the Department held a series of large public stakeholder meetings. This phase involved a large steering committee and the following workgroups:
  - **Systems Linkage Workgroup:** Purpose: To make a recommendation on those factors that should be present to promote "integration."

- o **State/Local and Non-Medicaid Workgroup:** Purpose: To make a recommendation on what services/financing should not be included in a "Medicaid" integrated care model and also make a recommendation on the roles that state and local government should perform.
- o **Evaluation and Data Workgroup:** Purpose: To determine what data is available and relevant to the ultimate recommendations on the model, and to make a recommendation on potential measures for evaluation.
- o **Chronic Health Homes Workgroup:** Purpose: To make a recommendation on a new "Health Home" service under the Affordable Care Act, and make a recommendation on how the new service could be developed to support any integration model.

Throughout the behavioral health integration process, there are a few providers, i.e. Mosaic, Inc. and Way Station, Inc., who are piloting health homes.

Once the report and the final recommendations, the culmination of all behavioral health integration efforts since 2011, is presented in FY 2013, Phase 3 will begin, which will involve developing specifications for the new system.

The Mental Hygiene Administration has been involved at all levels:
- Input into the Web site and Webinars
- Participation in the large stakeholder meetings and all Workgroups; leadership in the Systems Linkage and the State/Local and Non-Medicaid workgroups
- Communicating with stakeholders – consumers, providers, advocates, and others to inform and encourage feedback and participation in workgroups
- Dissemination of information on Maryland's Health Care Reform at MHA's State Plan Development meetings and other venues.
- Development of MHA's Annual Conference, *Health Care Reform and Mental Health*, held on May 4, 2012 and inclusion of ADAA in its planning process.

Strategy Accomplishment:
This strategy was achieved.

Objective 3.1. MHA will protect and enhance the rights of individuals receiving services and promote the use of advance directives in the PMHS.

(3-1A)
MHA's Office of Forensic Services, in collaboration with the Mental Health & Criminal Justice Partnership (MHCJP) and the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, will continue to promote the development of services to include diversion, housing, case management, and re-entry for individuals with mental illnesses who encounter the criminal justice system.

Indicators:
   • Provider linkages established
   • Participation in workgroup to plan re-entry
   • Increased capacity to exchange data between MHA and corrections system
   • Minutes of meetings (IFSC and MHCJP) provided

Involved Parties: Larry Fitch, Dick Ortega, Debra Hammen, and Lynn Edwards - MHA Office of Forensic Services (OFS); Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; CSAs; MHCJP;
the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Mental Health and Criminal Justice Partnership (MHCJP) continues to work with corrections, mental health, substance abuse, consumer and advocacy groups, and other key stakeholders in the areas of promotion of expansion of Motor Vehicle Administration (MVA) mobile van pilot which issues pre-release IDs and increased access to entitlements. MHA's Office of Forensic Services (OFS) staff participated in bimonthly meetings of the MHCJP and in subcommittee meetings on training for law enforcement agencies.

MHCJP has also been monitoring the implementation of Datalink, which enables the sharing of public mental health system treatment information with detention centers with appropriate client consent, in Baltimore City. Legal issues have been addressed and Baltimore Mental Health Systems (BMHS) is receiving the data and notifying providers when a client is arrested. Howard County is drafting a memo to implement a similar system in its jurisdiction. Also, DHMH has provided online access to Medicaid Management Information System (MMIS) eligibility screens for over 40 Department of Public Safety and Correctional Services (DPSCS) staff, and the agencies are collaborating in a daily exchange of inmate data so that DHMH can more readily identify those clients that have been incarcerated.

MHA participated in a joint DHMH-DPSCS Collaborative to plan for community re-entry of individuals with mental illness being discharged from correctional confinement. A key component of the planning addressed enhanced communication between DPSCS correctional officials and case managers from the PMHS. The collaborative submitted a Second Chance grant application to fund case managers to link discharged inmates with services in the community. The grant has since been awarded and implementation will begin in FY 2013.

Strategy Accomplishment:
This strategy was achieved.

(3-1B)
Provide training and technical assistance for MHA facility staff and community forensic evaluators regarding court orders for forensic mental health opinions in criminal and juvenile justice cases.
Indicators:
- Training provided on court evaluations and status reports
- Symposium held to include presentations to at least 200 DHMH-MHA facility staff, community providers, and other state agencies
- Technical assistance provided on services for individuals returning to the community

Involved Parties: Larry Fitch, Debra Hammen, Lynn Edwards and Dick Ortega - MHA Office of Forensic Services; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; University of Maryland Training Center

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
OFS staff met on a number of occasions with MHA facilities' staff and community providers to disseminate information and offer TA regarding issues facing court-involved consumers. Issues addressed included diversion, services for justice-involved consumers in the community, community reintegration, and consumer concerns regarding the delivery of forensic services.

OFS staff participated in the following academic trainings in which clinical professionals received certificates:

- The fifteenth Annual Symposium on Mental Disability and the Law held in the summer, 2012 in Columbia, Maryland. Two hundred mental health professionals and consumers attended.
- Finan Hospital Center staff trained on working with court involved individuals April 6, 2012. Participants numbered 25.
- Three-day training held for facility and community based forensic evaluators, November 16-18, 2011; approximately 20 participants.
- The ninth annual Juvenile Forensic Psychiatry Symposium, held August 25, 2011, for University of Maryland fellows and residents; approximately 40 participants.

Strategy Accomplishment:
This strategy was achieved.

Objective 3.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for children with emotional disabilities and individuals of all ages with psychiatric disorders and co-existing conditions, including but not limited to: court and criminal justice involvement, deaf and hard of hearing, traumatic brain injury (TBI), homelessness, substance abuse, developmental disabilities, and victims of trauma.

(3-2A)
Facilitate community placements, ensure access to somatic and mental health services, and monitor plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver.
Indicators:
- Five year renewal application completed
- Plans of care developed and monitored for approximately 60 TBI waiver participants
- Increased utilization of enhanced transitional case management to support program's expansion and increased enrollment
- Financial incentives identified to expand provider capacity
- Additional providers enrolled
- Eligible participants enrolled in Money Follows the Person Project (MFP), enhanced federal match spent on initiatives that increase community capacity
Involved Parties: Stefani O'Dea and Nikisha Marion, MHA Office of Adult Services; Medical Assistance Division of Waiver Programs; Coordinators for Special Needs Populations in MHA facilities; CSAs; TBI Advisory Board; community providers
MHA Monitor: Stefani O'Dea, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA is the lead agency in Maryland for current Traumatic Brain Injury (TBI) initiatives, which include a Home and Community-Based Services (HCBS) Waiver for individuals with TBI. In FY 2012, 61 individuals were served through this program. Plans of care were developed and updated as needed for all waiver participants. Waiver case management services recently changed from an administrative function at MHA to targeted case management services. Case management providers were enrolled. Transitional case management was utilized to provide program education, application assistance, and transitional case management for those individuals in their first year of waiver enrollment.

The TBI Waiver program capacity continues to expand to meet needs of target population. Of the 61 individuals, eight were enrolled in the Money Follows the Person Project (MFP), which utilizes HCBS waivers as the strategy for transitioning individuals from institutional settings to community-based services and enhances federal match spending on initiatives that increase community capacity. Two financial incentives were identified to expand provider capacity, although no additional providers enrolled.

MHA's TBI project staff continue to provide education and consultation to local mental health providers and other human service agencies on recognizing the signs of TBI and on strategies for affectively serving and supporting those individuals in the least restrictive setting. Additionally, MHA provides staff support to Maryland's TBI Advisory Board, which is legislatively mandated to report annually to the Governor and the General Assembly on the needs of individuals with TBI.

Strategy Accomplishment:
This strategy was achieved.

(3-2B)
Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, and other involved parties to implement recommended minimum standards upon approval by DHMH's Office of Behavioral Health and Disabilities to enhance access to services that are culturally competent, clinically appropriate, and recovery oriented for individuals who are deaf or hard of hearing and have co-occurring substance use disorders and/or developmental disabilities.

Indicators:
- Participation with DHMH's Office of Behavioral Health and Disabilities to determine standards to be adopted by the department
- Plan developed in collaboration with ADAA, DDA, and CSAs, to implement adopted standards based on department approval
- Council minutes and reports disseminated

Involved Parties: Marian Bland, MHA's Office of Special Needs Populations; DHMH's Office of Behavioral Health and Disabilities; Iris Reeves, MHA Office of Planning and Training; Marcia Andersen, MHA Office of Child and Adolescent Services; CSAs; ODHH; ADAA, DDA, consumers and family groups; state and local agencies, colleges and universities; local service providers

MHA Monitor: Marian Bland, MHA Office of Special Needs Populations

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA continues to participate in all quarterly Behavioral Health subcommittee meetings of the Maryland Advisory Council for the Office of Deaf and Hard of Hearing (ODHH). Additionally, the office hosts and participates monthly in the advisory board's behavioral health subcommittee.

In FY 2011, the behavioral health subcommittee revised and resubmitted recommendations to the Deputy Director of Behavioral Health and Disabilities. In FY 2012, due to the planning efforts towards the move to implement behavioral health integration, the focus has shifted. The goal is to advocate for the inclusion of the minimum standards into an integrated model. Three minimal standards which are now being collected through the PMHS' ASO, ValueOptions®Maryland, include: obtaining information regarding whether an individual is deaf or hard of hearing; a drop box for providers to indicate whether a person is deaf or hard of hearing under Axis III medical information. (this addition will allow the state to track the availability and types of resources available to serve those who are deaf or hard of hearing). Also MHA developed a uniform data reporting form for CSAs to report outpatient and interpreting services that are being provided through state general funds. CSAs also receive technical assistance, as appropriate, in addressing the needs of individuals who are deaf or hard of hearing.

MHA continues to work with the ODHH Advisory Council and the CSAs to develop strategies to improve access to outpatient treatment and improve the competencies of outpatient providers working with consumers who are deaf or hard of hearing. The Office recommended that the advisory council participate in State Health Improvement Plan (SHIP) and DHMH Behavioral Health Integration meetings to provide input into the

design of the new system to incorporate the needs and minimum standards for individuals who are deaf or hard of hearing.

Additionally, several trainings were held locally and regionally to focus on deaf and hard of hearing issues, cultural sensitivity, and awareness issues. Finally, MHA's Office of Special Needs Populations and the MHA Office of Consumer Affairs sponsored a consumer and advocate to attend a conference in Florida to obtain information from other states on best practices in serving individuals who are deaf or hard of hearing.

Strategy Accomplishment:
This strategy was achieved.

(3-2C)
MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies and/or selected local providers (local detention centers, hospitals and mental health clinicians) will partner with National Association of State Mental Program Directors (NASMHPD) and others to provide training and disseminate information regarding trauma-informed systems of care.
Indicators:
- Continued presentation of Trauma-informed Care/Trauma issues at the Supervisors' Academy for Co-occurring Disorders
- Senate Bill 556 Workgroup formed to increase safety at State Facilities; collaborative effort with NASMHPD and Maryland Disability Law Center (MDLC)
- Facilities staff trained on trauma informed care principles
- Clinical staff trained to provide trauma education/treatment through group work
- List of providers trained in trauma-informed care maintained
- Continued promotion of trauma-informed care through collaborative efforts with ADAA, DDA, and community health centers
- Increased public awareness of trauma's impact on behavior

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; Clarissa Netter, MHA Office of Consumer Affairs; CSAs; NASMHPD; local detention centers; hospitals, mental health clinicians, and advocacy groups
MHA Monitor: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

FY 2012 activities and status as of 6/30/2012 (end-year report):
In partnership with NASMHPD, MHA participated in trainings and presentations on trauma-informed care including Maryland's Trauma, Addictions, Mental Health, And Recovery (TAMAR) project, a program which provides treatment for incarcerated men and women who have histories of trauma and mental illnesses. Staff at state psychiatric hospitals have received training on trauma-specific models including TAMAR, other best practice models such as Seeking Safety, Motivational Interviewing, and the Trauma Recovery and Empowerment Model (TREM) [a manualized group intervention designed for women trauma survivors with severe psychiatric disorders]. Training on trauma care and trauma informed care for DDA facilities are planned for FY 2013.

Several programs in Maryland continue to involve trauma screening and trauma informed care as a component of standard care including: Chrysalis House/Healthy Start, a statewide diagnostic and transitional program for justice system involved, pregnant women as an alternative to incarceration; Seclusion and Restraint Reduction program in MHA facilities; and Traumatic Brain Injury (TBI) training in collaboration with other agencies.

Through the Alcohol and Drug Administration's (ADAA's) training division, the Office of Education and Training for Addiction Services (OETAS), psychotherapists, social workers, addictions counselors and others in the behavioral health field have received training on trauma-specific services and trauma-informed care. During the Supervisors' Academy for Co-occurring Disorders, MHA conducted a training session to help participants understand how trauma impacts treatment and recovery and how to apply this knowledge in their assessment and treatment of individuals with co-occurring disorders. MHA actively collaborates with the Maryland's Department of Public Safety and Correctional Services through the Female Offender Workgroup with program development and staff training on trauma informed care principles. The aggregate number of attendees for all FY 2012 presentations and trainings were close to 500. A list of organizations that have completed trainings is maintained.

Additionally, the 2011 Senate Bill (SB) 556/House Bill (HB) 1150 required specified facilities to provide clinical, direct care, and other staff with regular patient interaction training in trauma-informed care and to conform with trauma-informed care principles including reporting specified abuse, complaints of sexual abuse, or sexual harassment to the state designated protection and advocacy system. At the close of Calendar Year 2012, the SB 556/HB 1150 Advisory Committee will furnish a full report identifying the facilities' progress in meeting the deliverables.

Technical assistance on trauma related issues will continue to be offered to the state facilities as well as community providers.

Strategy Accomplishment:
This strategy was achieved.

(3-2D)

MHA, in collaboration with the Committee on "Aging in Place", will develop an integrated care model for consumers age 50 years and above, with behavioral and somatic health needs, in PMHS residential programs.

Indicators:
- Activities of the "Aging in Place" committee expanded to include additional provider input
- Cost analysis developed, assessment tools selected, jurisdictions determined
- Components of integrated care model identified
- Model adjusted to include inpatient settings and residential rehabilitation programs (RRPs)
- Model approved

Involved Parties: James Chambers, Marge Mulcare, Penny Scrivens, and Georgia Stevens – MHA Office of Adult Services; Committee on Aging in Place; DHMH Office of Health Services; Office of Health Care Quality (OHCQ); CSAs; the Mental Health Association of Maryland (MHAMD); CBH

MHA Monitor: James Chambers, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Aging in Place Committee has moved forward in FY 2012 to finalize identification of a model of integrated care ready for Medicaid funding that will address the somatic needs of older adults living in residential rehabilitation programs (RRPs) with added provisions for consumers served on the inpatient units. The committee received input from all stakeholders with significant input from DDA Nurses in determining the best model for consumers in RRPs. This committee completed its work and identified two models for MHA's consideration to address this population of consumers with serious complex medical needs:

- Phase I will be a consulting nurse model, designed to support consumers in the current RRP setting.
- Phase II will be a community-based long term care model for consumers who are no longer capable of directing their own care.

The specifics of each model are spelled out in the final report presented to the Executive Director of MHA in November 2011. Integrated care models are identified in the final report. Models are recommended for final approval by MHA's Executive Director.

A cost analysis was not completed but recommendations were made to enhance and cost-out each model recommended.

Strategy Accomplishment:
This strategy is achieved.

Objective 3.3. MHA, in collaboration with CSAs, consumer and family organizations, governmental agencies, the administrative services organization (ASO), and other stakeholders, will address issues concerning improvement in integration of community services.

(3-3A)   *Federal Mental Health Block Grant*
Continue to monitor crisis response systems, diversion activities, and community aftercare services to increase the diversion of inpatient and detention center utilization by individuals with mental illnesses.
Indicators:
- Stakeholder workgroups convened to refine service descriptions, curricula, certification processes (where applicable), and professional qualifications in regulations of residential and mobile crisis (as well as peer support and supported employment services)
- Workgroup recommendations used in working with Maryland Medicaid to make above services eligible for federal payment
- Number of uninsured individuals diverted from emergency departments, MHA facilities, other inpatient services, and detention centers
- Number of alternative services provided
- Reduction of emergency department requests for admission to state hospitals
- Service continuum plan developed

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; James Chambers, MHA Office of Adult Services; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Facility CEOs; Larry Fitch, MHA Office of Forensic Services; Alice Hegner, MHA Office of CSA Liaison; Clarissa Netter, MHA Office of Consumer Affairs; Randolph Price, MHA Office of Administration and Finance; CSA directors in involved jurisdictions; other stakeholders

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director; Gayle Jordan-Randolph, MHA Office of the Clinical Director; and Melissa Schober, MHA Medicaid Policy Analyst

FY 2012 activities and status as of 6/30/2012 (end-year report):
The Peer Support Medicaid Work Group continues to meet to identify and develop a curriculum that would enable consumers in Maryland to qualify as Peer Support Specialist and receive Medicaid funding for the services they provide. Due to the many efforts required to move MHA toward integration and the many demands placed on Medicaid, this initiative was placed on hold for a large portion of calendar year 2012. However, this committee has reconvened and in FY 2013, will continue meeting until a final curriculum recommendation is presented to the Executive Director and Deputy Director of MHA for their approval. Once approved, this will be the first step toward completing the Medicaid Application Process for consideration of Medicaid Funding Approval for Peer Support in Maryland.

The implementation of the hospital diversion activities in several counties, as well as the increase in purchase of care (POC) beds, have contributed to expanded access to community-based inpatient services and decreased civil admissions to state facilities.

Although, in FY 2010, the hospital diversion pilot projects were discontinued, as originally designed, particularly due to enforcement of the Emergency Medical Treatment and Labor Act (EMTALA), which legislates that hospitals and emergency departments cannot turn down an admission because the individual is uninsured, MHA continues to track hospital diversion data from the involved jurisdictions. Based on FY 2012 data from Montgomery, Anne Arundel, Harford counties and Baltimore City, the total number of calls made to crisis response systems was 107,495; the number of mobile crisis team face to face visits was 5,640; the number of individuals receiving in-home intervention was 800; and the number of individuals seen for urgent care visits was 5,463. Of the uninsured individuals receiving services within these jurisdictions in FY 2012, 152 converted to Medicaid through Primary Adult Care (PAC).

Additionally, the total number of alternative services provided to veterans in these jurisdictions is as follows:
- Calls coming into the crisis response system – 157
- Face to face visits from the mobile crisis services team – 52
- Number seen through urgent care visits – 15

Statewide in FY 2012, the total number of individuals (children, youth, and adults) receiving mobile treatment services, based on PMHS claims paid through September 30, 2012, was 2,984*.

Other local efforts toward judicial diversion services continue. Carroll and Harford counties have mental health diversion programs. Calvert, Mid-shore, and Prince George's counties support a liaison between the jail and the courts to recommend community-based mental health services as a diversion to detention or incarceration. Based on data reported to MHA's Office of Forensic Services, Mid-shore served approximately 69 individuals in its Forensic Mental Health Program with 19 receiving case management. Calvert County CSA found 71 individuals, in FY 2012, appropriate for court diversion services. Harford County's mobile crisis and diversion programs were identified by the Bazelon Center for Mental Health Law for success in providing options for treatment in lieu of incarceration for individuals with serious mental illness (SMI). The county was selected in 2012, by SAMHSA and the Bazelon Center, to host site visits to provide understanding of its capacity for preventive and early intervention services to address the problem of the criminalization of individuals with SMI. In addition to working with the counties, MHA continues to partner with Baltimore City CSA to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). FAST also diverts individuals from jail and connects them to services.

In FY 2011, based on data reported through Baltimore Mental Health Systems CSA, FAST conducted 976 screenings and monitored 40 court-involved individuals in the community. In FY 2012, it is expected that the program will have screened more than 1000 individuals and monitored at least 43 in the community.

Strategy Accomplishment:
This strategy was achieved.

*__This includes all group coverage types: Medicaid, Medicaid State funded, and uninsured.__

(3-3B)   **Federal Mental Health Block Grant*
In collaboration with the Centers for Medicare and Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 210 children and youth and their families.
Indicators:
- Number of Waiver providers enrolled, (including youth and family peer support providers)
- Number of youth enrolled
- Implementation of waiver quality assurance plan

Involved Parties: MHA Office of Child and Adolescent Services; Maryland Child and Adolescent Mental Health Institute; Maryland Medicaid (MA); CSAs; Care Management Entities (CMEs); Maryland Coalition of Families for Children's Mental Health; Maryland Association of Resources for Families and Youth (MARFY); Governor's Office for Children (GOC); the Children's Cabinet; Local Management Boards (LMBs)
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA continued implementation of the Centers for Medicare and Medicaid (CMS) sponsored psychiatric residential treatment facility (PRTF) demonstration, which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services.

MHA drafted a 1915(c) waiver renewal application, submitted by Maryland Medicaid to CMS, for the continuance of the PRTF demonstration project. The waiver will only be available for youth admitted prior to September 30, 2012 because of federal statutory limitations on the duration of the demonstration. MHA has received and responded to questions posed by CMS on this application and expects approval of the waiver application. MHA has worked with GOC to provide care management through a statewide Care Management Entity (CME) for all youth enrolled in the PRTF demonstration project.

Current enrollment, as of the end of FY 2012, was 124 individuals. There are currently 32 enrolled providers of specialized waiver services, with many of these providers offering more than one type of waiver service.

The waiver is guided by a federally required Quality Assurance Plan which was implemented last year with discovery and plans of correction. A serious incident reporting mechanism has been established and is producing useful quality improvement information.

In addition to the 1915(c) waiver renewal outlined above, MHA and Medicaid submitted the results of a quality management plan monitoring to CMS, which requested further clarifications and information in the process of approval. A series of site visits to waiver providers is currently being planned.

Strategy Accomplishment:
This strategy was achieved.

(3-3C)   *Federal Mental Health Block Grant*
In collaboration with Maryland Medicaid, review and amend Maryland's State Medicaid Plan to include community mental health services; once revised, submit amendments for approval to the Centers for Medicare and Medicaid Services (CMS).
Indicators:
- Service descriptions, curricula, and certification processes (where applicable) refined and/or developed
- Professional qualifications for psychiatric rehabilitation programs (PRPs), supported employment, peer support, and residential and mobile crisis services refined and/or developed
- A 1915(i) state plan amendment drafted to include PRP and supported employment as Medicaid-reimbursable services; peer support and crisis services submitted separately to accommodate further regulatory development
- The 1915(i) state plan amendment refined and submitted to CMS

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; James Chambers and Penelope Scrivens, MHA Office of Adult Services; Alice Hegner, MHA Office of CSA Liaison; Randy Price, MHA Office of Administration and Finance; Maryland Medicaid-Office of Health Services
MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

FY 2012 activities and status as of 6/30/2012 (end-year report):
Maryland Medicaid and MHA are continuing to review the entire State Medicaid Plan and update its pages accordingly. To ensure full compliance with the Social Security Act and Code of Federal Regulations, the section on Outpatient Mental Health Clinics will be moved to the Clinic Section of the State Medicaid Plan.

MHA has participated in several workgroups comprised of consumers, providers, and other stakeholder groups to examine services. Service descriptions and professional qualifications for Psychiatric Rehabilitation Programs and Supported Employment Programs were developed. Descriptions for peer support and mobile and residential crisis providers and services were in-process. Progress on service descriptions and professional qualifications has been halted as the Department of Health and Mental

Hygiene (DHMH) moves forward with the integration of MHA and ADAA, into a single behavioral health agency.

Several activities are underway for the planning and implementation of behavioral health integration. DHMH has convened large stakeholder workgroups to inform the recommendation for a new Medicaid financing model. The proposed models include: a protected carve-in of behavioral health services; a risk adjusted and/or performance-based carve-out of services; and a behavioral health organization response for those with serious mental illness or serious co-occurring disorders. Due to the behavioral health integration process, MHA delayed submission of amendments to the Medicaid State Plan. Once the recommendation of a Medicaid financing model for Behavioral Health is presented, activities related to submission of amendments to the Medicaid State Plan will resume (i.e., 1915(i)). However, efforts to develop Chronic Health Homes (an approach to health care, consisting of a team of health care professionals that provide integrated health care and linkages to long-term community care services and supports) will continue.

Additionally, in October 2011, MHA (in conjunction with the State Medicaid Agency) submitted a successful application and was awarded funding for the Medicaid Emergency Psychiatric Demonstration Project, established under the Affordable Care Act. Maryland will be one of 11 states along with the District of Columbia to participate to test whether Medicaid beneficiaries who are experiencing a psychiatric emergency get more immediate, appropriate care when institutions for mental diseases receive Medicaid reimbursement.

Strategy Accomplishment:
This strategy was achieved.

(3-3D)   *Federal Mental Health Block Grant*

MHA's Office of Special Needs Populations, in collaboration with ADAA, and DDA, will provide information and extend technical assistance through training and promotional materials to health agencies regarding the identification, education, and treatment of consumers with trauma histories.

Indicators:

- Identification of key screening and assessment tools of trauma, such as Screening, Brief Intervention, Referral, and Treatment (SBIRT) and the Adverse Childhood Experiences questionnaire, to be utilized as the standard tool for all practices across systems and agencies (emergency rooms, military, criminal justice, child-serving systems, etc.)
- Technical assistance, general public education, and social marketing (including consumers, general assembly, etc.) provided on trauma to ensure culturally competent, trauma-informed systems and better coordinated service systems
- Identification of Evidence-Based Practices (EBPs) - science-informed practices with proven outcomes - and workforce enhancement needs to address identified gaps.
- Necessary regulatory changes determined and financing strategies developed including federal funding opportunities (grants, MA, health care reform) and cross-system duplication to fund gaps in trauma-focused intervention and treatment.

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; Clarissa Netter, MHA Office of Consumer Affairs; ADAA; DDA; community health centers; mental health clinicians; advocacy groups

MHA Monitor: Darren McGregor, MHA Office of Special Needs Populations

FY 2012 activities and status as of 6/30/2012 (end-year report):

MHA continues to monitor use of screening tools in programs funded through the Administration. Maryland's Trauma, Addictions, Mental Health, And Recovery (TAMAR) project, a program which provides treatment for incarcerated men and women who have histories of trauma and mental illnesses, uses a variety of tools such as the Adverse Childhood Experiences (ACE) and the Brief Jail Mental Health Survey. ADAA tends to utilize the SBIRT. MHA will continue to collaborate with DDA to explore its screening tool preferences. In FY 2013, the resulting information will assist the Administration in deciding on a standard tool which will meet its needs. Also, MHA distributes a manual on trauma-informed care to all TAMAR training participants with the understanding that technical assistance will be provided as needed.

Additionally, the 2011 Senate Bill (SB) 556/House Bill (HB) 1150 legislation required specified facilities to provide clinical, direct care, and other staff with regular patient interaction training in trauma-informed care. At the close of Calendar Year 2012, the SB 556/HB 1150 Advisory Committee will furnish a full report identifying the facilities' progress in meeting the deliverables.

MHA has identified evidence-based and best practice models to be effective with consumers with trauma histories such as Seeking Safety, Motivational Interviewing, and the Trauma Recovery and Empowerment Model (TREM) [a manualized group intervention designed for women trauma survivors with severe psychiatric disorders]. Additionally, TAMAR is moving toward becoming an evidence-based practice. In FY 2013, pre and post evaluations of each TAMAR module will be developed in cooperation with a University of Baltimore doctoral student.

Strategy Accomplishment:
This strategy was achieved.

GOAL IV. PROVIDE A COORDINATED APPROACH TO INCREASE
EMPLOYMENT AND PROMOTE INTEGRATION OF SERVICES AND
TRAINING TO DEVELOP AND SUSTAIN AN EFFECTIVE
BEHAVIORAL HEALTH WORKFORCE.

Objective 4.1. MHA, in collaboration with CSAs and state agencies, will develop employment options and supports to increase the number of consumers employed.

(4-1A)
Continue to implement the Maryland Mental Health Employment Network (MMHEN), a consortium of Maryland mental health supported employment providers and CSAs, to increase and enhance the array of choices of supported employment services available by utilizing Social Security Administration incentives such as Ticket-to-Work.
Indicators:
- Continued administrative infrastructure and operation of MMHEN at Harford County Office on Mental Health (the Core Service Agency)
- Data reported on number of programs participating and consumers receiving training in these programs
- Number of consumers receiving individual benefits counseling in the Ticket-to-Work Program

Involved Parties: Steve Reeder, MHA Office of Adult Services; Maryland Department of Disabilities (MDOD); Work Incentives Planning and Assistance (WIPA) Project; University of Maryland Evidence-Based Practice Center (EBPC); Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ValueOptions®Maryland

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA, in collaboration with the Social Security Administration (SSA), Maryland State Department of Education-Division of Rehabilitation Services (MSDE-DORS), the Harford County Core Service Agency (CSA), and the evidenced-based supported employment providers, continued its demonstration project under the auspices of the Ticket-to-Work (TTW) regulations which is known in Maryland as the Maryland Mental Health Employment Network (MMHEN). This program helps SSA disability beneficiaries with SMI to obtain and retain employment, while developing a career path that will lead to economic and personal self-sufficiency. Ninety-eight individuals received training, were employed, and retained benefits under this program in FY 2012 through five participating providers - Alliance, Goodwill STEP, Mosaic, Humanim, and St. Luke's House.

MMHEN was chosen by SSA to participate in the Trusted Financial Partner Program, a pilot program in which the Employment Network (EN) works directly with SSA rather than SSA's TTW contractor. The result has been a marked improvement in payment turn-around and needed assistance from SSA. Also, SSA's contractor that manages the Ticket to Work program substantially expanded methods to exchange data (including

internet video phone (IVP) access to records and an on-line portal) in order to accurately assign tickets to participating agencies such as the MMHEN. Finally, the MMHEN has set up a new wage reporting system that reduces wage reporting burden for providers. Wage information and TTW status continue to be tracked monthly by the Harford County CSA. The TTW specialist is now designated as a nationally Certified Work Incentive Coordinator which adds legitimacy and recognition to her competencies and may lead to potential grant opportunities.

In FY 2012, a total of 35 individuals received benefits counseling. MMHEN partners with OOOMD to provide benefits counseling to consumers involved with evidence-based supported employment (EB-SE) providers so they understand SSA's work incentives and protections.

In FY 2013, MMHEN hopes to further expand the role of benefits counseling to individuals who are not working with EB-SE community providers. Also, in FY 2013, MHA will explore expanding the MMHEN to include transition-age youth and/or other individuals with mental illness who are in need of employment supports.

Strategy Accomplishment:
This strategy was achieved.

(4-1B)
MHA, in collaboration with NAMI MD and the University of Maryland Evidence-Based Practice Center (EBPC) will implement the Johnson & Johnson - Dartmouth Community Mental Health Program Family Advocacy Project to educate family members as to the role of supported employment (SE) in consumer recovery.
Indicators:
- Increased understanding of MHA's supported employment program by consumers, transition-age youth, and families
- SE resource person trained and available at selected local NAMI affiliates – Metro Baltimore, Frederick, Howard, and Montgomery county organizations
- Content for Family-to-Family classes available to selected NAMI affiliates
Involved Parties: Steve Reeder, MHA Office of Adult Services; Carole Frank, MHA Office of Planning and Training; Maryland Department of Disabilities (MDOD); University of Maryland Evidence-Based Practice Center (EBPC); Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ValueOptions®Maryland
MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
In FY 2011, the Family Advocacy Team comprised of MHA's Director of Vocational Services and Evidence Based-Practices, MHA's Director of Consumer Affairs, NAMI's Family-to-Family State Coordinator/EBP training consultant, and three additional NAMI members representing four large NAMI MD affiliates, traveled to New Hampshire for an intensive two-day training on SE under the auspices of the Johnson & Johnson – Dartmouth College Community Mental Health Program. The purpose of this program, known as the Family Advocacy Team Project in Maryland, is to increase awareness of SE as an EBP among family members of persons with serious and persistent mental illness.

NAMI's Family to Family curricula were revised and implemented in Montgomery County to include Family Advocacy Team Project content. Training content for the Family Advocacy Team Project was added to Family-to-Family classes (F2F) available to selected NAMI affiliates through Montgomery and Prince George's counties (77 trained). Nationally, the Family Advocacy Team leader provided a national NAMI Family-to-Family (F2F) Education Program state teacher training at the Johnson & Johnson – Dartmouth Annual Conference in St. Louis in spring 2012 for 27 NAMI members returning to their states to train future F2F teachers.

Workshops have been sponsored regionally on benefits counseling targeting family members, consumers, and providers. Additional workshops on supported employment have been presented at NAMI MD's Annual Conference, Baltimore County Town Hall, and bi-monthly through the Evidence-based Practice Center. More than 140 participants received training and information. Outcomes are sent quarterly to the Johnson & Johnson - Dartmouth Community Mental Health Program.

NAMI MD advertised the events via their Web site as well as through electronic notification to its membership, reaching upwards of 7,000 Marylanders. Also, team members introduced the Family Advocacy Team Project to Community Behavioral Health (CBH) monthly supported employment representatives and collaborated with them to develop, for distribution, a two-sided fact sheet describing what family members and employment specialists can expect from each other. This fact sheet was provided for distribution by NAMI and EBP Supported Employment programs. MHA and NAMI representatives now meet regularly with the CBH employment agencies to promote ways to support families whose relatives want to work.

A NAMI Montgomery Executive Director was trained on benefit incentives in March 2012 and now is available to all NAMI MD affiliates as a supported employment resource person.

In the remaining two years of the project, NAMI MD will receive funding to offset incurred expenses related to providing educational SE information to families.

Strategy Accomplishment:
This strategy was achieved.

Objective 4.2. MHA will develop and implement collaborative training initiatives involving other agencies and stakeholders serving individuals with psychiatric disorders in the PMHS.

(4-2A)
Continue to enhance workforce development by expanding the involvement of Peer Employment Resource Specialists (PERS).
- Medicaid workgroup convened to explore the possibility of making peer support services eligible for the PMHS fee-for-service system
- Peers involved in disseminating person centered planning to consumers
- Use of Network of Care Web site to identify workforce development issues and career opportunities

Involved parties: Clarissa Netter, MHA Office of Consumer Affairs; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; OOOMD; CBH; mental health advocacy groups; peer organizations

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2012 activities and status as of 6/30/2012 (end-year report):
In FY 2011, the Peer Support Medicaid Work Group was established to identify and develop a curriculum that would enable consumers in Maryland to qualify as Peer Support Specialist and receive Medicaid funding for the services they provide. Earlier in FY 2012, efforts to further this initiative were put on hold due to the planning activities of the DHMH Behavioral Health Integration process. However, the work group has reconvened and MHA has established linkage with ADAA to have full representation from all consumers and staff with interest in mental health and substance abuse concerns. The final recommendations for curriculum will be presented to MHA leadership for approval. Once approved, this will be the first step toward completing the Medicaid Application Process for consideration of Medicaid Funding Approval for Peer Support in Maryland.

The Peer Employment Resource Specialist (PERS) training has been facilitated throughout the state. To date there have been more than 86 consumers who have graduated from the PERS program. This training affords Peers to offer support and assistance to others in their recovery while addressing their own employability, development planning, and job development. In FY 2012, follow-up PERS training sessions took place specifically for PERS graduates to enhance these abilities.

Other efforts to increase peer employment resource development take place through the Maryland Consumer Volunteer Network which has implemented activities to promote leadership skills and create workforce development initiatives throughout the system. In FY 2012 efforts were underway to upgrade computer technology to facilitate access to a variety of programming opportunities including the use of Network of Care.

Strategy Accomplishment:
This strategy was achieved.

(4-2B)   *Federal Mental Health Block Grant*

Expand intensive skills-based training opportunities to include motivational interviewing, person centered planning, and core concepts of recovery and resilience to increase the effectiveness of service delivery within the PMHS.

Indicators:
- Number of motivational interviewing trainings given to providers
- Number of person centered planning trainings held for consumers and providers
- Number of trainings on core concepts of recovery and resilience
- Number of participants trained in each of the above
- Pre/post test, anecdotal evidence of skill improvement

Involved Parties: University of Maryland Training and Evidence Based Practice Centers; Cynthia Petion and Carole Frank, MHA Office of Planning, and Training; James Chambers, MHA Office of Adult Services; Clarissa Netter, MHA Office of Consumer Affairs; Resilience Sub-Committee of the Maryland Blueprint Committee; Joan Smith, MHA Office of Child and Adolescent Services; Lisa Hovermale, MHA Office of the Executive Director; Value Options®Maryland; Core Service Agencies; providers; Motivational Interviewing Network of Trainers; consumers

MHA Monitor: Carole Frank, MHA Office of Planning and Training

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA continues efforts to promote skill-based client-centered opportunities.

Motivational Interviewing
Motivational interviewing (MI) is considered to be an approach that is both client-centered and directive with the goal of helping individuals move toward positive change. Skill improvement has been evident through class exercises, evaluations, and anecdotal reports for about 280 participants in motivational interviewing sessions in 2012. Of that number, 220 were trained through various agencies, 25 were trained at Clifton T. Perkins Hospital Center, and 35 participants were trained through the Supervisors' Academy for Co-occurring Disorders. During one of the sessions, the VASE-R, a tool for rating proficiency, was used. It indicated improvement in MI skills as a result of the training.
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Person Centered Care
Person centered planning or person centered care (PCC) is designed to enable people to direct their own plan for services and supports and is in concert with MHA's emphasis on a recovery-oriented system of care. In FY 2011, two train-the-trainer sessions were conducted by a national expert in person centered care for a core group of trainers including the Evidence-based Practice Center (EBPC). In FY 2012, these trained trainers held trainings in the following areas: peer support, evidence-based practices, traumatic brain injury, co-occurring (including mental health with developmental disabilities or with substance abuse), and aging.

Also, in FY 2012, the Peer Support Specialists and the Director of the MHA Office of Consumer Affairs coordinated PCC training with consumer trainers who worked with participants on Assertive Community Treatment (ACT) teams to prepare them to be active participants in their treatment planning processes. As a vehicle for training and disseminating person centered care concepts, the EBPC also worked with supported employment programs and ACT teams to set up a Supervisors Collaborative for each

discipline. The Collaboratives had 30 participants trained in PCC to: introduce person-centered care to their teams/organizations; determine its impact on practice and documentation; review requirements when vocational plans are being developed to reflect the principle of the PCC approach; and effectively utilize this approach to supervise staff. All together, 328 participants were trained in PCC from a variety of agencies, collaboratives, and ACT Teams.

Additionally, on Sept. 20, 2011 a presentation was made to the Maryland Advisory Council on Mental Hygiene/Planning Council on implementation of person centered planning efforts in Maryland. Thirty-eight Council members attended. Further trainings from the consultant to the master trainers and Peer Support Specialists on ACT teams will be offered in the coming year and EBPC trainers are continuing to offer TA.

Recovery and Resilience
Resilience is the ability to rebound and positively adapt to adversity, stress and change. The value of recovery and resilience across the Life Span is that it helps individuals (re)establish a sense of wellness and competency. A Resilience grant was awarded through MHA to University of Maryland in April to implement resilience based practice and to determine if this approach results in better outcomes. The results will be reviewed in FY 2013. Also, the Prevention and Resilience Committee submitted a report in June on Wellness, Prevention, and Early Intervention activities implemented over seven months toward behavioral health Integration for MHA's Office of Child & Adolescent Services' SAMHSA System of Care grant.

In FY 2012 the following trainings were accomplished:
- Presentation on the Resilient Caregiver at the annual Caregiver Conference, October 24, 2011
- Resilience Workshop at the annual Targeted Case Management Conference, April 14, 2012
- Resilience presentation done for parents in Wicomico County, June 28, 2012
- Resiliency and Recovery across the Life Span training for MHA staff, May 16, 2012

The Recovery and Resilience training for the staff of MHA's Offices of Adult Services and Child and Adolescent Services was based on the recognition that it was important for staff in both Offices to know what was being done in areas of Resilience and Recovery and understand the common elements of both. Approximately 250-300 people were involved in these efforts and trainings in FY 2012.

Strategy Accomplishment:
This strategy was achieved.

MHA, in collaboration with DHMH, ADAA, and DDA, will convene a workgroup to develop an action plan for behavioral health workforce development.

Indicators:

- Workgroup convened
- Available infrastructure to support and coordinate workforce development evaluated
- Increased use of data to track, evaluate, and manage key workforce issues
- Needs assessment conducted to determine workforce capacity
- Recruitment and retention issues addressed

Involved Parties: MHA; DHMH; ADAA; DDA; other stakeholders

MHA Monitor: Carole Frank, MHA Office of Planning and Training

FY 2012 activities and status as of 6/30/2012 (end-year report):

The workgroup was convened, and an extensive document produced that provides a comprehensive map of all workforce committee, task forces, etc, in the state (with a special focus on activities between ADAA/MHA and DDA). The document included each committee's name, current charge, focus, history and recent activity. The workgroup also researched the progress of other states such as the Connecticut Workforce Collaborative whose focus is on co-occurring and evidence-based practices.

Also, Maryland's infrastructure was evaluated; Children's Policy Day resources, data issues, and recruitment and retention issues were reviewed. The workgroup also focused on workforce development in relation to health care reform, SAMHSA's strategic initiatives, and expansion of the behavioral health workforce.

Additionally, the workgroup promoted the Supervisors' Academy for Co-occurring Disorders which enhanced skills and integration of supervisors from three administrations, ADAA, DDA and MHA. This year there were two regional groups which met simultaneously from Western Maryland and the Eastern Shore. Monthly trainings focus on basic co-occurring competencies.

The Governor's Health Care Coordinating Council requested and received input from the DHMH workgroup as the Governor worked to create a workforce development workgroup to address workforce needs statewide.

As DHMH's development of its behavioral health integration process moves forward, expansion of the workforce to meet current and future needs is a significant focus. An action plan is not yet completed. However, a needs assessment is in the planning stages for FY 2013. Results of this assessment is expected to provide further input to formulate a plan and to assist providers and consumers alike, who will need education and practical information to prepare for integrated care.

Strategy Accomplishment:

This strategy was partially achieved.

The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and Maryland State Department of Education (MSDE), will develop a mental health training model for educators and continue to promote the use of curricula for training of staff in child mental health professions based on established core competencies.

Indicators:
- Training modules marketed for undergraduate and graduate–prepared individuals to receive continuing education units (CEUs) via Web-based educational technology; number of individuals completing modules
- Mental health training modules/core competencies for educators developed to assist them in working with children, and their families, with mental health needs

Involved Parties: MHA Office of Child and Adolescent Services; MHA Office of Planning and Training; MSDE; the Maryland Child and Adolescent Mental Health Institute; professional schools representing higher education; the Maryland Coalition of Families for Children's Mental Health; provider agencies; local school systems

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
A set of core competencies in child and adolescent mental health has been developed by the Maryland Interdisciplinary Mental Health Workforce Committee, under the leadership of the MSDE Division of Special Education/Early Intervention Services and MHA, to be utilized in Web-based curricula and in the classrooms of Maryland colleges and universities. The core competencies have led to the development of training modules in the following content areas:

1.   Child Development
2.   Youth and Families as Partners
3.   Screening, Assessment, and Referrals
4.   Treatment Planning and Service Provision
5.   Outcomes and Quality Improvement
6.   Behavior Management
7.   Health and Safety
8.   Community Development
9.   Communication
10.   Cultural and Linguistic Competence

The training has been developed and field tested for utilization in existing master's degree programs and its Web-based technology has been established through the University of Maryland's Innovations Institute Web site. Also, CEUs are awarded for mental health professionals and para-professionals. This on-line training is a component of a Virtual Training Center, and is also suited for Navigators and others who help individuals to navigate the Public Mental Health System. These curricula are also being used for continuing education and in-service training for the existing nursing workforce.

The numbers of individuals completing these modules are tallied by the newly renamed Center for Innovation & Implementation and are presented at year end. So far in 2012, 387 individuals have received certificates of completion with Child Development being

the most frequented module. The training can be accessed through
http://mdvtc.umaryland.edu/TrainingAreas/CoreCompetencies.aspx

Strategy Accomplishment:
This strategy was achieved.

(4-2E)
Collaborate with Department of Public Safety and Correctional Services (DPSCS), the judiciary, law enforcement, CSAs, and community stakeholders to develop cross-educational events concerning mental health services for justice-involved individuals.
Indicators:
- Training for police upon request
- Collaboration on a cross-education event with parole and probation personnel and community mental health stakeholders
- Collaboration on a cross-education event with court personnel (judges, states' attorneys, public defenders, and clerks)

Involved parties: Larry Fitch, Lynn Edwards, and Debra Hammen - MHA Office of Forensic Services; Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; CSAs
MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
In FY 2012, MHA, in collaboration with law enforcement agencies and local crisis response systems, offered four police trainings regarding the management of crises involving persons suspected of committing an offense who appear to have a mental illness. These trainings on *Responding to the Person with Mental Illness and the Emergency Petition for Police Officers* were held at the Baltimore Police Academy in Baltimore City and were conducted by MHA's Office of Forensic Services. Presentations focused on the practical decisions that police officers have to make in the field and were delivered in plain, non-technical language. The presentations are continuously updated by MHA to reflect recent developments in the law and best practices. A total of 164 police personnel were trained.

Also, four trainings including - Introduction to Serious Mental Illness, and Crisis Intervention with the Person with Mental Illness and De-escalation Through Delay - were conducted for Clifton T. Perkins Hospital Center security officers and clinicians. Sixty-four security officers and five clinicians were trained.

Additionally, a training on competency to proceed in juvenile court, and adolescents' risk of violence, was held in the spring for the Masters in Chancery; 20 participated. An overview of issues in mental health and corrections was presented to 45 Montgomery County Criminal Justice Coordinating Council members and other county officials in winter 2012.

Strategy Accomplishment:
This strategy was achieved.

Objective 4.3. Develop initiatives that promote the delivery of culturally competent and ethnically appropriate services.

(4-3A)
MHA, in collaboration with key stakeholders, will continue the development and implementation of cultural competence training activities for consumers, providers, staff, and individuals in the PMHS.
Indicators:
- Incorporation of data from cultural competence assessment tool in curricula development
- Develop a proposal to sustain Cultural and Linguistic Competency Training Initiative (CLCTI) training based on lessons learned
- Data analyzed by Systems Evaluation Center (SEC) of CLCTI evaluation
- Training modified on cultural and linguistic issues and system issues with additional emphasis, where appropriate, on regional and geographic differences
- Incorporation of cultural sensitivity and awareness for specific populations i.e. deaf and hard of hearing, TBI, lesbian, gay, bi-sexual, transgender, questioning, (LGBTQ), and individuals who are homeless

Involved Parties: Iris Reeves, MHA Office of Planning and Training; Marian bland, MHA Office of Special Needs Populations; Clarissa Netter, MHA Office of Consumer Affairs; other MHA staff; CSAs; Maryland Advisory Council on Mental Hygiene/Cultural and Linguistic Competence Advisory Committee (CCAC); consumers; family members; advocacy groups

MHA Monitor: Iris Reeves, MHA Office of Planning and Training

FY 2012 activities and status as of 6/30/2012 (end-year report):
Efforts to promote cultural competence and meet the needs of an increasingly diverse population continue to be important components of Maryland's mental health system of care. MHA's Multi-Cultural Coordinator was involved in the following activities:

Cultural and Linguistic Competency Training Initiative (CLCTI)
In FY 2010, the goal of the Cultural and Linguistic Competency Training Initiative (CLCTI) was to provide training and consultation to several adult Psychiatric Rehabilitation Programs (PRPs) to promote program changes that would increase the cultural competency of the program and its recovery-orientation. Six PRP teams (27 participants) completed the formal training and worked with the Trainers/Consultants. Throughout FY 2011 and 2012, the 27 participants identified goals to be accomplished over a 9 -12 month period of time to make each program more culturally competent. MHA offered technical assistance in the form of identification and enhancement of program demographic data, onsite cultural competence training as requested, assistance in development of newsletters and resource directories, and assistance in development of "welcoming environments" that reflected the racial/ethnic diversity of the program.

In FY 2011 and during FY 2012, Data analyses of the CLCTI evaluations were completed by SEC and shared with MHA. These reports were utilized by the CLCTI consultants and the PRP teams to identify program needs and areas of technical assistance. Some of the areas included:

- Needs and nature of cultural competence for deaf and hard of hearing;
- Maximization of the provision of services for individuals identified with the LGBTQ community and to establish LGBTQ group
- Needs of individuals who are homeless

Additionally, a modified training model has been developed to be utilized with small regional groups, special needs populations and geographically different groups. Since the inception of the CLCTI Project, more than 550 individuals have received, at a minimum, this modified 2-3 hour CLCTI training which has been well received.

Core Service Agencies
FY 2013 Core Service Agencies (CSA) Plans for all jurisdictions were reviewed as they planned and managed efforts in the local mental health communities.   Comments and technical assistance were offered on cultural competence activities where available, to promote cultural competence towards becoming an integral part of all initiatives, trainings, and programs.

Support of Activities for Specific Populations
MHA consults with the Governor's Office of Deaf or Hard of Hearing (ODHH) on resources as well as collaborates to address consumer and/or system related issues; coordinates or sponsors cultural sensitivity and awareness trainings; and provides data on number of deaf and hard of hearing consumers served at Springfield Hospital Center and/or in the community. MHA's Office of Special Needs Populations held a one-day conference in which the ODHH presented a workshop on cultural sensitivity and awareness for providers working with individuals who are deaf or hard of hearing. Planning is underway with Arundel Lodge staff, the Arundel Lodge CLCTI team, and the ODHH to provide, in FY 2013, cultural competence training for management and clinicians specific to the deaf or hard of hearing population.

Technical assistance, as requested, was available from MHA and the resources of the LGBTQ association and churches that have services and activities inclusive of all sexual orientations, to assist two provider agencies, in Prince Georges and Harford counties, with the formation of LGBTQ support groups. Hearts and Ears, a LGBTQ Wellness & Recovery Center in Baltimore City, has offered several outreach sessions during the fiscal year on topics such as: "The Gay Community and Stereotypes"; Mental Health First Aid; and a workshop on community resources for LGBTQ individuals who are homeless with mental illnesses.

Cultural and Linguistic Competence Advisory Committee
The Cultural Competence Advisory Group (CCAG) was formed in 1997 in partnership between MHA and the previous ASO (Maryland Health Partners) and consists of a diverse group of members, including consumers, from various racial/ethnic backgrounds, as well as clinicians and administrators who serve minority populations. The CCAG assists MHA in increasing awareness of issues of cultural competence within a system that promotes resilience, recovery, and wellness. In July 2011, CCAG became a sub-committee of the Maryland Advisory Council on Mental Hygiene/PL 102-321 Council and is now known as the Cultural and Linguistic Competence Advisory Committee (CCAC). The Committee works to ensure a more culturally competent PMHS and promotes training regarding culturally and linguistically appropriate competence.

In April 2012, Senate Bill 234, Maryland Health Improvement and Disparities Reduction Act of 2012, was passed by the Maryland legislation to establish a process for the designation of Health Enterprise Zones to target state resources to reduce health disparities, improve health outcomes, and reduce health costs and hospital readmissions in specific areas of the state. Under this act, a workgroup was established to examine these issues. A representative of the CCAC participates on this workgroup which will, among other things, recommend ways to strengthen cultural competency and health literacy training and assessments, as required by this legislation.

Cultural Competence Assessment Tool (CCAT)
Consultants/trainers followed closely the conception of the Cultural Competence Assessment Tool (CCAT), developed by MHA Cultural Competence Advisory Group to evaluate consumer and staff perception of cultural competence of providers/programs. There was informal incorporation of the data information from pilot testing of the tool, into the CLCTI curriculum. In the final analysis, the Systems Evaluation Center (SEC) concluded the CCAT is reliable, valid, requires no changes, and is ready to be used in its present form as a means of assisting behavioral health programs to offer more culturally and linguistically competent services.

Strategy Accomplishment:
This strategy was achieved.

GOAL V. BUILD PARTNERSHIPS TO INCREASE THE PROVISION OF AFFORDABLE HOUSING AND REDUCE BARRIERS TO ACCESS IN ORDER TO PREVENT HOMELESSNESS FOR INDIVIDUALS WITH MENTAL ILLNESS.

Objective 5.1. Evaluate and develop opportunities to maximize current resources to promote affordable safe housing for individuals with serious mental illness.

(5-1A)

Continue to work with other state and local funding resources to promote and leverage DHMH's Administration-Sponsored Capital Program grant (Community Bond) funding to support an array of affordable and integrated housing choices for individuals with serious mental illness (SMI).

Indicators:

- Community bond housing applications approved to increase funding for supported and independent housing units
- Meetings with participating providers and non-profit organizations held
- Continued partnership with the Maryland Department of Housing and Community Development (DHCD), other state and local agencies, and funding entities to encourage participation in annual community bond proposal
- Monitored implementation of the Weinberg Foundation Grant with DHCD, DHMH, and MDOD to select participants for the program
- Past and present capital projects, that have been funded and implemented, reviewed to accurately report on number of units, number of persons served as well as documentation of annual progress and barriers in sustaining the housing generated by Community Bond

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Robin Poponne, MHA Office of Planning and Training; Marian Bland, MHA Office of Special Needs Populations; DHMH Office of Capital Planning, Budgeting, and Engineering Services; Money Follows the Person; CSAs; DHCD; MDOD; Developmental Disabilities Administration (DDA); Maryland Department of Aging (MDoA); Centers for Independent Living (CILS); Maryland Partnerships for Affordable Housing (MPAH); local housing authorities; housing developers; Consultant Staff of Technical Assistance Collaborative (TAC)

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA's priority for Administration-Sponsored Capital Program grant (Community Bond) financing is the development of affordable housing projects. Through the DHMH Community Bond a total of $4.5 million was approved for FY 2012 to serve individuals with mental health needs, by providing new housing options under this program. To date, more than 500 housing units have been developed through Community Bond funding and the following entities, including mental health provider organizations: Main Street Housing, Prologue, Humanim, Way Station, Supported Housing Developers, Community Housing Associates, Key Point, Alliance, Family Services Foundation, Mosaic, Crossroads, People Encouraging People, Project PLASE and others. Additionally, other supported housing providers, as well as a few developers, have applied for tax credits through DHCD and are working on blended funding projects to serve individuals coming out of the state hospitals or stepping down from Residential Rehabilitation Programs (RRPs).

MHA is committed to further reductions in the hospitals' census. Diverting individuals from admissions and/or discharging individuals from the hospitals can assist in reducing the hospital census. This includes individuals transitioning from RRPs to Supported Housing so that individuals in state hospitals may access the vacant RRP beds. In 2011, a collaborative effort among Springfield Hospital Center, Housing Unlimited, Inc. (HUI), and the Montgomery County CSA, community bond funding was leveraged with the goal of transitioning 20 Springfield Hospital Center patients over two years into RRPs. The residents in the RRP programs would move into supported housing provided through HUI. Funding to match the Community Bond award came from Springfield Hospital Center budget to offer rental assistance to tenants moving into HUI units. To date, nine individuals have been placed in HUI supporting housing units.

Also, MHA's strong interagency collaboration with DHCD and the Department of Disabilities (MDOD) has resulted in increased housing options for consumers of behavioral health services. In May 2011, an announcement was made by Governor Martin O'Malley to highlight efforts between DHCD, Weinberg Foundation, and DHMH to fund non-profit developers with capital financing to offer housing units to persons at Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) level of income. Under a Memorandum of Understanding, the Weinberg Foundation and the above mentioned state agencies will work together to finance affordable, quality, independent, integrated housing opportunities for very low income persons with disabilities who meet certain eligibility criteria. The Weinberg units will house non-elderly, disabled households at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. Monthly meetings are held with other housing partners to address the waiting list process for Weinberg units as well as prepare for the possibility of future Program for Rental Assistance (PRA) units available from HUD.

On January 26, 2012 MHA and DHMH Community Bond staff convened a meeting to inform potential provider/applicants of the benefits of community bond funding as a way to increase affordable housing options and to explain the application process. More than 30 provider/organizations were represented and the number of applicants for FY 2014 awards increased by eight (12 in total) above the previous year. Subsequent meetings with providers were held as needed to provide technical assistance, address changes, and delineate the inclusion of appropriate special populations.

Strategy Accomplishment:
This strategy was achieved.

(5-1B)
MHA will analyze data related to entry and exit from Residential Rehabilitation Program (RRP) placements to identify characteristics associated with successful movement from RRPs to more independent settings and develop strategies to disseminate relevant findings to the provider community.
Indicators:
- SEC report of admissions and discharges to and from RRPs
- Analysis plan developed and implemented to study information from current practices within the RRP
- Number of individuals who moved from state hospitals to RRPs and/or to supported housing
- Findings incorporated into future planning for RRPs
- Continued updates and implementation of the RRP Survey Manual developed by hospital staff, providers, and CSAs to transition individuals to the community

Involved Parties: James Chambers and Penny Scrivens, MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Robin Poponne, MHA Office of Planning and Training; Marian Bland, MHA Office of Special Needs Populations; SEC; DHMH Office of Capital Planning, Budgeting, and Engineering Services; CSAs; MHA facilities; CBH; RRP providers; Supported Housing providers
MHA Monitor: Penny Scrivens, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA conducts an ongoing group with RRP providers, CSAs, and state hospitals to reduce the number of vacancies in the RRP, identify ways to in-reach (providers come to meet and educate patients about their services) with patients in the hospital by offering access to resources such as: local and state administered funding such as HOME and the HUD Community Development Block Grant (CDBG); benefit applications; delivery of Supplemental Social Security, Outreach, Access, and Recovery (SOAR) training; and conducting training for RRP providers on working with individuals with forensic needs. Also, case management and other agencies assist individuals with disabilities to look for accessible and affordable housing. Supported Housing providers, as well as a few developers applying for tax credits through DHCD, are working on blended funding and resources already established in the community to serve individuals coming out of the state hospitals or stepping down from RRPs.

An analysis plan is being discussed with MHA Hospital Management Information System (HMIS) and SEC to make data available through SEC reports as well as through ValueOptions®Maryland. The RRP statistics submitted by Core Service Agencies to MHA's Office of Adult Services is currently under review in order to evaluate data from the ASO. However, statistics available from the ASO showing the admissions and discharges from RRPs over the years 2009, 2010 and part of 2011, show an increase in the number of consumers moving out of RRPs. The number of consumers leaving the hospital has increased due to outreach by providers and collaboration with clinics and other community-based resources. Ongoing partnerships with local public housing authorities (PHAs) and other housing programs have assisted with helping individuals to step down from their placement in the community to more independent housing.

The RRP Survey Manual was developed by hospital staff, providers, and CSAs to detail the process that promotes movement from RRPs into Supported Housing or other independent living situations. The manual is reviewed annually with housing information added or updated and distributed by MHA to providers, CSAs, and hospitals.

Strategy Accomplishment:
This strategy was achieved.

(5-1C)
MHA, in collaboration with CSAs, federal Department of Housing and Urban Development (HUD), local public housing authorities (PHAs), and other federal, state, and local entities, will work with housing infrastructures to improve and increase the number of housing options and funding opportunities for rental assistance for individuals with mental illnesses.
Indicators:
- Increased availability of vouchers through Money Follows the Person Initiatives, the Non-Elderly Disabled HUD Notice of Funding Availability (NOFA), and collaboration with local public housing authorities (PHAs)
- RRP provider training continued on the needs of individuals with forensic involvement
- Collaboration with community-based entities to post available units through the Web site: mdhousing.org
Involved Parties: Penny Scrivens, MHA Office of Adult Services; Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; CSAs; DHCD; MDOD; DDA; MDoA; Centers for Independent Living (CILS); local housing authorities; housing developers
MHA Monitor: Penny Scrivens, MHA Office of Adult Services

<u>**FY 2012 activities and status as of 6/30/2012 (end-year report):**</u>
MHA has worked toward efforts to increase availability of housing vouchers through the following processes:

- MHA participates in working with a steering committee – Maryland Partnership for Affordable Housing (MPAH) Advisory Group – chaired by MDOD and Money Follows the Person representatives, to implement the changes within the HUD 811 program in preparation for the HUD Notice of Funds Availability (NOFA), which are posted throughout the year for HUD projects.
- MHA continues to monitor [along with the Technical Assistance Collaborative (TAC) and other state and local agencies] developments in funding with HUD for special groups such as veterans (VASH), Non-Elderly Disabled (NED) vouchers, as well as the NOFA announcing new initiatives through HUD 811. As funding (including special funding that can assist with developing uniform and fair referral system) becomes available, MHA notifies agencies eligible to apply.
- Case management and other agencies assist individuals with disabilities to look for accessible and affordable housing in Carroll, Baltimore, Montgomery, and Howard counties, as well as Baltimore City, to utilize NED vouchers (Category I and II) for persons who cannot access affordable housing in senior-only buildings. In 2012, 260 NED vouchers for Category I were distributed and 112 vouchers for Category II in Maryland.

MHA participates in an ongoing interagency group meeting every other month to access vacancies and access resources and supports.

Under a Memorandum of Understanding, the Weinberg Foundation and state agencies are working together to finance affordable, quality, independent, integrated housing opportunities for persons with very low income who have disabilities and meet certain eligibility criteria. The Weinberg units will house non-elderly individuals with disabilities at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. Work with local public housing authorities (PHAs) will continue to help secure access to and stability in housing for consumers. A referral process for Weinberg Housing units and HUD 811 (when awarded) will be coordinated through MDOD to place consumers on a waiting list for community-based supported housing is in the process of being developed.

Also, MHA works with Mental Health Association of Maryland (MHAMD) to do training, problem solving, and looking at ways to improve outcomes with individuals with mental health/substance abuse disorders leaving correctional institutions and moving into the community: These resources and supports include: ID process, employment, case management, housing and other ways to help improve linkages with clinics and other programs. MHAMD continues to be a partner in the process through participation in committees, policy review, contracts for services, and other measures to improve efforts to serve persons with criminal involvement.

Additionally, the DHCD Web Site, mdhousing.org , continues to be a resource for land lords to post vacancies and for tenants and future tenants to explore possible available units.

Strategy Accomplishment:
This strategy was achieved.

(5-1D)
In collaboration with participating CSAs, develop a pilot that brings state and local partners together to increase access to adequate transportation across the state, which will impact access to housing and employment opportunities.
Indicators:
- A survey conducted of CSAs to determine interest and participation in a pilot to evaluate current public transit services and offer recommendations to improve public transportation access in their jurisdiction
- Changes to schedules and routes outlined and implemented as determined by the survey/pilot and the local agencies
- Evaluation at intervals (determined by the agencies/CSAs) to provide feedback and changes to the pilot
- Funding sources researched to sustain project and educate other jurisdictions on lessons learned and positive outcomes

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; CSAs; Maryland Department of Transportation (MDOT); DHCD; MDOD; DDA; MDoA; CILS; local housing authorities; housing developers

MHA Monitors: James Chambers and Penny Scrivens, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
A decision was made not to administer a survey or develop a pilot at this time. MHA found it more useful to become a resource for technical assistance to encourage CSAs to research and establish networks with local transportation systems and local governments within their jurisdiction, as an initial step towards meeting transportation needs and promoting local systems of change.

Strategy Accomplishment:
This strategy was partially achieved.

(5-1E)
Identify partners to support accessible, affordable, and inclusive housing to consumers and families across the life span - children and families, transition-aged youth, and older adults - in addition to individual adult eligibility.

Indicators:
- Agencies that provide housing in Maryland surveyed to look at models for providing housing across the life span
- Models identified that support person centered planning, cultural diversity, access to services and promote health and well-being to individuals of all ages
- Recommendations made for support of models to be integrated into current planning for future housing expansion

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; CSAs; DHCD; MDOD; DDA; MDoA; CILS; local housing authorities; housing developers

MHA Monitors: James Chambers and Penny Scrivens, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
Agencies that provide supported housing in Maryland were surveyed to look at their models for providing housing across the life span. Housing models such as group homes, transitional housing, independent 1-2 bedroom apartments, etc. were documented. This also includes housing that addresses the need for physical accommodations. The survey results will assist in also identifying housing models that support person-centered care, cultural diversity, access to services, and promote health and well-being to individuals of all ages.

The results will be reviewed in FY 2013 in conjunction with criteria for Medicaid's Balancing Incentive Payments Program (BIPP). This program aims to increase shifts in state Medicaid spending towards community-based care. While recommendations are not yet developed, MHA will be looking at the results and the BIPP criteria to support models that will be integrated into current planning for future housing expansion.

Strategy Accomplishment:
This strategy was partially achieved.

Objective 5.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for individuals who are homeless.

(5-2A)
Realign Projects for Assistance in Transition from Homelessness (PATH) funding to focus services on the delivery of outreach, case management, and recovery for individuals who are homeless or at imminent risk of becoming homeless.
<u>Indicators</u>:
- Submission of application to Substance Abuse and Mental Health Services Administration (SAMHSA) for continued PATH funding
- Provision of technical assistance to providers and CSAs to realign services to meet funding priorities
- Utilization of a small portion of grant to provide one-time-only funds to prevent eviction
- Data gathered on number of individuals who are homeless and are assisted through PATH

<u>Involved Parties</u>: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; other MHA staff; CSAs; PATH service providers, DHCD
<u>MHA Monitors</u>: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

<u>FY 2012 activities and status as of 6/30/2012 (end-year report):</u>
In FY 2012, the PATH program provided services to individuals who were homeless or at imminent risk of becoming homeless in all four geographic jurisdictions - Central, Eastern, Southern and Western - in Maryland. Baltimore City and all 23 counties in Maryland received PATH funding. SAMHSA notified MHA on July 14, 2011 that continued funding was awarded. The total federal funding was $1,284,000.

Local PATH supported agencies identified 6,294 homeless individuals with mental illnesses. Of these, 2,251 actually enrolled for PATH services.

PATH provides on-going technical assistance to providers and CSAs to ensure they are meeting funding priorities under SAMHSA Recovery Model initiative. In addition, four quarterly meetings were held this year.

Out of the 25 PATH providers in the state of Maryland, 19 provide outreach services and case management which meet SAMHSA's goal to link individuals to community mental health and other services as needed. In FY 2012, five counties were approved to provide one-time-only funds to prevent evictions and 31 individuals were assisted.

Quarterly reports provide a snapshot of PATH services provided during the year. Based on these, an Annual Progress Report, which indicates the exact number of individuals receiving outreach services and enrolled in the PATH program, is submitted to SAMHSA to provide statewide data on individuals who are homeless and who were assisted through PATH for the year, as well as the services and linkage to housing.

Strategy Accomplishment:
This strategy was achieved.

(5-2B)
Maximize use of the Shelter Plus Care Housing funding and other support systems to provide rental assistance to individuals with mental illnesses who are homeless, or were formerly homeless, using federal Department of Housing and Urban Development (HUD) funding; explore other funding opportunities to provide housing assistance for special needs populations, i.e. women who have histories of mental illness, trauma, and substance abuse who are transitioning to the community with children.
Indicators:
- Partnerships developed to seek funding to meet needs of women with children who are transitioning to the community
- Sources of funding researched
- Application for funding submitted
- Number of families/individuals housed, services provided
- Technical assistance and trainings provided to CSAs, providers, and local continuum of care committees to facilitate the generation of new referrals, development of flexible budgets to increase the availability of housing, and expansion of landlord participation

Involved Parties: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; Penny Scrivens, MHA Office of Adult Services; ADAA; CSAs; MHA facilities; Continuum of Care Homeless Boards; local detention centers; HUD; Chrysalis House Healthy Start Program; local service providers; consumers
MHA Monitors: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA continues to provide federal HUD funding to CSAs to provide rental assistance to individuals who are homeless or were formerly homeless. In FY 2012, MHA was awarded funding in the total amount of $4.6 million for the 19 Shelter Plus Care renewal grants. The renewal grant award was slightly increased due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants.

MHA's Shelter Plus Care Housing program provided rental assistance to 194 families, 159 single individuals, 331 children along with 35 other adults. In total, 754 persons were housed. The total number of units in Shelter Plus Care Housing was 354.

In addition to the housing the families received an array of supportive services through state, local, and private agencies. Services included mental health treatment, case management, alcohol and substance abuse services, health care, legal services, child care, etc.

MHA's Office of Special Needs Populations continues to participate in local Continuum of Care Homeless Boards, provide technical assistance to providers on a daily basis via telephone, email, or written correspondence, assist with resolving crisis situations or handling problematic situations that occur or may occur. In addition, MHA meets with CSAs, case managers, consumers, Shelter Plus Care monitors, and providers quarterly. Performance Reports are submitted to HUD yearly which includes the number of individuals served and the amount and type of supportive services received during the course of the year.

The Shelter Plus Care program exceeded the number of units that HUD authorized MHA to serve. In December 2011, HUD approved MHA's applications for continued funding. MHA's Shelter Plus Care Housing will be funded for FY 2013 for a total of 317 units.

Strategy Accomplishment:
This strategy was achieved.

(5-2C)
Expand Supplemental Social Security, Outreach, Access, and Recovery (SOAR) statewide; establish new partnerships with the Veterans Administration (VA), colleges and universities, hospitals, and other state and local agencies; explore funding opportunities to support SOAR implementation and services.
Indicators:
- Additional SOAR sites developed and workgroups formed
- State Planning workgroup expanded
- Partnerships created with Veterans Administration and other agencies
- New partners trained in SOAR
- Social Work students assigned to field sites
- Funding sources, other than PATH, obtained
- SOAR certification adopted in Maryland
- State Work Plan goals accomplished
- Technical assistance provided to develop a local planning group, create local SOAR projects, and increase knowledge of the SOAR application process and data collection tool

Involved Parties: Marian Bland, Caroline Bolas, and Keenan Jones – MHA Office of Special Needs Populations; Iris Reeves, MHA Office of Planning and Training; Policy Research Associates, Social Security Administration; Disability Determination Administration; colleges and universities; DPSCS; DHR; Veterans Administration; Prince George's County Department of Social Services; Health Care for the Homeless; PATH-funded providers; other community and facility-based providers
MHA Monitors: Marian Bland and Caroline Bolas, MHA Office of Special Needs Populations

FY 2012 activities and status as of 6/30/2012 (end-year report):

Since July 1, 2011, MHA's Office of Special Needs Populations worked with Baltimore, Frederick, Harford, St Mary's, and Washington counties in developing work plans to implement the SOAR initiative. Providers in these counties have undergone SOAR training and are now participating in the SOAR Initiative. MHA has also held start-up meetings and provided on-going support to a workgroup in Cecil County. This increase has supported the growth of SOAR within Maryland and has resulted in a significant increase in the number of successful SSI/SSDI applications being submitted using the SOAR process. Also, in FY 2012, 185 people were trained in the SOAR process. Approved SOAR applications numbered 126 with the average processing time of 73 days (2 ½ months) for initial cases. This compares with 112 claims in FY 2011 (initial cases completed on average in three months).

Additionally, MHA's Office of Special Needs Populations provided on-going technical support to those counties that have previously implemented SOAR, namely, Anne Arundel, Carroll, Howard, Montgomery, Prince George's, Somerset, and Wicomico counties and Baltimore City.

A number of new partners have joined the overall State Planning workgroup, including representatives from DORS, SSA, Veterans Administration (VA), and DHR. Despite not being able to continue SOAR training as scheduled (due to a VA National directive), the VA has continued to be very committed to partnering on the SOAR Initiative. A work plan has recently been developed in Baltimore City which looks to partner with the local VA medical center to support the effective implementation of SOAR. A social work student, at Health Care for the Homeless in Baltimore County, worked on SOAR cases during FY 2012. Additionally, a Public Health Nursing program student worked with MHA to evaluate aspects of the SOAR program and an undergraduate from a local School of Public Health worked with the SOAR project in Montgomery County.

During the reporting period, 185 people completed six two-day Stepping Stones to Recovery trainings which provided an in-depth, step by step explanation of the SSI/SSDI application and disability determination process. Participants consisted of case managers, PATH providers, human service providers and social workers. Additionally, during FY 2012, MHA started a pilot SOAR Certification Program in Baltimore City and Montgomery County. The purpose of the program is to ensure high quality SOAR applications. As of the end of June 2012, four providers hold provisional status and four people hold full certification status. Additionally, MHA provides technical support to nine active SOAR trainers within the state.

FY 2013 funding from Maryland's Alcohol Tax Appropriation, in part, will pay for state identification cards and birth certificates for individuals who are homeless and have a mental illness or co-occurring substance use disorder. All counties and Baltimore City will have access to these funds. Additionally, the project will fund five dedicated SOAR case managers who will provide outreach, assistance with applying for SSI/SSDI using SOAR components, and assistance with applying for other entitlements.

Strategy Accomplishment:
This strategy was achieved.

GOAL VI. UTILIZE DATA AND HEALTH INFORMATION TECHNOLOGY TO EVALUATE, MONITOR, AND IMPROVE THE QUALITY OF PMHS SERVICES AND OUTCOMES

Objective 6.1. MHA, in collaboration with Core Service Agencies (CSAs); consumer, family and provider organizations; and state facilities will identify and promote the implementation of models of evidence-based, effective, promising, and best practices for mental health services in community programs and facilities.

(6-1A)   *Federal Mental Health Block Grant
Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment (SE), assertive community treatment (ACT), and family psycho-education (FPE).

Indicators:
- Annual evaluations of programs to determine eligibility for EBP rates
- Increased number of programs meeting fidelity standards for EBP programs
- Number of new programs established
- Ongoing data collection on EBPs receiving training, meeting fidelity, and providing consumer services

Involved Parties: James Chambers, Penny Scrivens, and Steve Reeder - MHA Office of Adult Services; Brian Hepburn, MHA Office of the Executive Director; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Carole Frank, MHA Office of Planning and Training; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; ValueOptions®Maryland; the University of Maryland Evidence-Based Practice (EBPC) and Systems Evaluation (SEC) Centers; CSAs; community mental health providers

MHA Monitors: James Chambers and Steve Reeder, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
Fidelity assessments for programs offering the EBPs of ACT, FPE and SE are conducted by MHA Fidelity Monitors annually to determine a program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score a minimum of 4.0 on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate.

MHA, the University of Maryland's Evidence-based Practice Center (EBPC), and the Systems Evaluation Center (SEC) continue to work collaboratively on consultation; training; and technical assistance related to supported employment (SE) as an EBP service approach. Five new SE programs are in training to become EBPs and all SE programs provide quarterly outcome measures.

Three new ACT teams (Baltimore, Howard, and Worcester Counties) are in training to become EBPs. ACT evaluators are being trained in how to administer the *Tool for Measurement of Assertive Community Treatment* (TMACT). Currently piloted in several states, TMACT is still undergoing revisions and refinements. This tool will be used for quality improvement purposes until the research is completed. Fidelity scoring for ACT teams will continue to rely on the *Dartmouth Assertive Community Treatment Scale* (DACTS), which has been the assessment tool used to monitor Maryland ACT services since 2002, until TMACT research is completed. MHA continues to monitor ACT outcomes and ACT programs are piloting a process of monthly submissions of outcome measures.

For Family Psycho-education (FPE), there are currently three providers who have met the fidelity standards in their provision of FPE. These providers also offer technical assistance to sites across the state and assist ACT teams upon request.

(6-1B)   *Federal Mental Health Block Grant*
MHA, in conjunction with the University of Maryland Systems Evaluation Center (SEC), will aggregate, cross-match, and triangulate data from multiple data sources related to the implementation of supported employment (SE) to ensure the integrity and accuracy of data as a means to promote systems integration and to further inform data-driven, interagency policy development and program planning.
Indicators:
- SE claims and Division of Rehabilitation Services (DORS) data analyzed; EBP provider reports completed
- Report submitted by SEC
- Information disseminated to provider community
- Strategies developed, findings incorporated into future planning

Involved Parties: MHA Office of Adult Services; University of Maryland EBPC and SEC; DORS
MHA Monitors: Steve Reeder and James Chambers, MHA Office of Adult Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
In collaboration with MHA, DORS, and the Evidence-Based Practice Center (EBPC), staff of the SEC performed comparisons of the reports of consumer employment as recorded in DORS data system and reported to the EBPC. Eighty-seven percent of individuals who were reported as employed in the DORS management information system for FY 2011 also had a PMHS SE claim on file for the period beginning July 1, 2010 and 71.2% of those had a PMHS SE claim on file that indicated that they were employed. Slightly different definitions and claims requirements were cited as the most likely reasons for not achieving a perfect match between the data sets. While work on this data comparison project will continue into FY 2013, the goal of completing an analysis with the DORS files has been completed.

Additionally, MHA receives quarterly reports on outcome measures collected from supported employment EBP providers. With respect to comparisons of PMHS SE claims with data recorded by the EBPC, differences in methodology are even more pronounced. The differences in reporting of individuals employed ranged from 1.6% to over 94%.

However, differences of less than 20% were observed from over 60% of the 21 agencies reporting. It was noted that all but three of these agencies had higher percentages of people reported as "employed" through the PMHS claims system. While more intense examination of outliers may be indicated, most of the differences are clearly due to the differences in the definition of "employed" between the two reporting systems since the EBP definition is more stringent than the requirement for filing a claim that is indicative that the individual is employed.

The proposed data analysis has been completed. MHA will continue to meet with SEC in FY 2013 to review and discuss the data, to determine follow-up strategies, and to incorporate such strategies into future interagency policy development and program planning efforts.

Strategy Accomplishment:
This strategy was achieved.

(6-1C)
In collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health, continue the efforts of the Maryland Child and Adolescent Mental Health Institute to explore and implement child and adolescent evidence-based practices (EBPs) and other promising practice-based models.
Indicators:
- Pilot projects with University of Maryland on Family-Informed Trauma Treatment continued, employing Trauma-Informed Cognitive Behavioral Therapy models in selected sites around the state
- Collaboration with the Children's Cabinet to implement a range of EBPs across all child-serving systems (Multi-Systemic Therapy, Functional Family Therapy)
- Wraparound fidelity monitored in the context of the 1915(c) waiver and other interagency demonstrations
Involved Parties: Al Zachik and Joan Smith, MHA Office of Child and Adolescent Services; the Children's Cabinet; Carole Frank, MHA Office of Planning and Training; MSDE; University of Maryland and Johns Hopkins University Departments of Psychiatry; CSAs; CBH; Maryland Coalition of Families for Children's Mental Health; Maryland Association of Resources for Families and Youth (MARFY); MHAMD; other advocates; providers
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
Wraparound fidelity is monitored semi annually by the University of Maryland. Results are included in MHA's StateStat reports. Fidelity monitoring informs how well the Care Management Entities (CMEs) are adhering to the principles of Wraparound. Fidelity is assessed through interviews with families and team members using the Wraparound Fidelity Index (WFI-4) which includes between 34 and 40 items for each of three respondents. These respondents include: (1) the identified youth; (2) a caregiver; and (3) a member of the child and family team. These data have been tracked for the semi-annual periods beginning in January and July of each calendar year since 2008. Fidelity data are shared with the CMEs, coaches, trainers, providers, and the Children's Cabinet every six months to enhance quality improvement efforts. Scores for each type of respondent are compared to the following standards: Scores between 65 and 75 represent borderline fidelity; scores between 76 and 85 are considered adequate fidelity; and scores above 85 are considered high fidelity. The following results are averages for all wraparound recipients surveyed in Maryland for the six months ending December 31, 2011, which is the most recent data:

- Caregivers scored 71 in the borderline range while
- Youth and team members scored 80 and 76 respectively both in the adequate range.

Other EBPs currently tracked in Maryland are Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT). MST is provided by four separate providers in a total of eight jurisdictions and FFT is provided by four separate providers in a total of 18 jurisdictions. The funding for these two EBPs comes primarily from the Department of Juvenile Services (DJS), which tracks them as a part of its own StateStat measures. DHMH is not currently a funder of these programs. In addition, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) was implemented by the University of Maryland in FY 2011 under independent grant funding and, as of FY 2012, TF-CBT training has been conducted in Montgomery and Eastern Shore counties, Baltimore City, and for DJS staff.

In FY 2012, as a result of reorganization within the University of Maryland, responsibility for EBP oversight was transferred from the School of Medicine to the School of Social Work. As a result of this reorganization, FY 2012 data on FFT, TF-CBT, and MST is currently not available for inclusion in this report but will be made available in future reporting periods when it has been aggregated.

Strategy Accomplishment:
This strategy was achieved.

(6-1D)

MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies, local detention centers, DHMH and DPSCS's criminal justice team, and other key stakeholders, will develop and implement new practices to provide cost effective, coordinated, recovery-oriented services to individuals who have mental illnesses or co-occurring substance abuse disorders who are incarcerated in local detention centers or prisons.

Indicators:

- Identification of pre-trial best practices
- Identification of post-trial assessment best practices
- Engagement in partnerships to promote data sharing to assist with re-entry
- Engagement of Wellness and Recovery Centers in aftercare planning
- The feasibility assessed of the Maryland Community Criminal Justice Treatment Program (MCCJTP) and the Trauma, Addiction, Mental Health, and Recovery (TAMAR) Project to meet the aftercare needs of its participants

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; Debra Hammen, MHA Office of Forensic Services; Core Services Agencies; local detention centers; MHAMD; Wellness and Recovery Centers; ADAA; DDA; community behavioral health providers

MHA Monitors: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

FY 2012 activities and status as of 6/30/2012 (end-year report):

MHA, through the Trauma, Addictions, Mental Health, and Recovery (TAMAR) Project and the Maryland Community Criminal Justice Treatment Program (MCCJTP), continues to collaborate with local leaders of mental health and correction services to identify, assess, and provide interventions to justice-involved individuals with mental illness and substance abuse. MHA's program development and technical assistance has helped expand services for this population in the community. MHA continues its collaboration with DPSCS, the Maryland Correctional Administrators Association, CSAs, and other partners to identify best practices for pre-trial mental health assessments. All detention centers screen for mental health issues through their medical unit. Assessment tools, such as the Brief Jail Mental Health Survey, the Cage Assessment Tool, and Adverse Childhood Experiences (ACE) survey currently in place in local detention center focusing on trauma services.

Quarterly meetings are conducted and quarterly reports are submitted for the 22 counties participating in MCCJTP. These reports include data for the number of consumers served; data for the number of hours delivered for psychiatry, psychotherapy, and case management; and reports for selected site visits. DHMH, DPSCS, and the ASO continue to explore technology that allows pertinent mental health information to be shared across organizations.

TAMAR continues with 90 day follow up after discharge to monitor aftercare needs. Plans are set for FY 2014 to put into place additional enhancements for aftercare service monitoring for MCCJTP.

Strategy Accomplishment:
This strategy was partially achieved.

Objective 6.2. MHA will monitor and evaluate the performance of its key contractors the administrative service organization (ASO) and the Core Service Agencies (CSAs), requiring improvement as needed.

(6-2A)   *Federal Mental Health Block Grant*
In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care for at least the same number of individuals.
Indicators:
- Contract requirements monitored
- Information shared with key stakeholders
- Monthly and quarterly reports generated by ASO; analysis of reports by involved parties
- Analysis of utilization management practices

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Audrey B. Chase, MHA Office of Compliance; MHA Management Committee; ValueOptions®Maryland; CSAs; representatives of key stakeholder groups

MHA Monitor: Daryl Plevy, MHA Office Deputy Director for Community Services and Managed Care

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA has continued to serve individuals of all ages with mental illnesses, even as it has assumed fiscal and administrative responsibility for mental health care for the total Medicaid population under the MA 1115 waiver. In FY 1999 (first year of available data), more than 68,000 individuals were served. Sixty-three percent were adults and 37 percent were children and adolescents. Fifty-two percent met the diagnostic criteria for serious mental illness (SMI) and 72 percent met the criteria for serious emotional disorder (SED). Over the last thirteen years, the number served has grown to more than 142,993 individuals who had claims paid for mental health services received through the fee-for-service system. Of the total, at least 87,668, approximately 61 percent (61.3%) were adults (age 18+) and 55,325, almost 39 percent (38.7%) were children and adolescents. More than 63 percent (63.24%) of adults served met the diagnostic criteria for SMI and more than 75 percent (75.06%) of the children and adolescents served met the diagnostic criteria for SED. (Data collected by claims paid through July 31, 2012 and therefore is approximate due to the allowed twelve month lag in PMHS claims submission).

MHA is continuing to serve individuals of all ages with mental illnesses, even as it has assumed fiscal and administrative responsibility for mental health care for the total Medicaid population under the MA 1115 waiver. The number of individuals served has grown by more than 74,000 since FY 1999, the first year of available data.

<u>Strategy Accomplishment</u>:
This strategy was achieved.

(6-2B)
Review, in collaboration with the administrative services organization (ASO) and CSAs, providers' clinical utilization, billing practices, and compliance with regulations.
<u>Indicators</u>:
- Number of audits conducted
- Audit reports and compliance activities reviewed
- Corrective actions identified/implemented as needed

<u>Involved Parties</u>: Audrey B. Chase, MHA Office of Compliance; Daryl Plevy, MHA
  Office of the Deputy Director for Community Programs and Managed Care;
  James Chambers, MHA Office of Adult Services; Al Zachik, MHA Office of
  Child and Adolescent Services; DHMH's Office of Health Care Quality (OHCQ);
  ValueOptions®Maryland; CSAs
<u>MHA Monitor</u>: Audrey B. Chase, MHA Office of Compliance

<u>FY 2012 activities and status as of 6/30/2012 (end-year report)</u>:
In FY 2012, MHA's Office of Compliance worked with the administrative services organization (ASO) to ensure the completion of 63 outpatient program audits and seven inpatient program audits. All audits were conducted as retrospective reviews of services provided. Provider entities included psychiatric rehabilitation programs (PRPs), outpatient mental health clinics, residential treatment centers, and hospitals. During this reporting period, the audit-focus on in-patient settings (Residential Treatment Centers and hospitals) was decreased so that more attention could be placed on PRPs for minors. Corrective actions were identified and implemented through scheduled retractions, an approved Performance Improvement Plan, and/or Settlement Agreement.

In all instances audit findings were presented in a formal audit report. MHA's Office of Compliance continues to work with the Office of the Inspector General to prevent fraud and abuse as well as identify opportunities for further investigation and recovery.

<u>Strategy Accomplishment</u>:
This strategy was achieved.

(6-2C)
Review and approve CSA mental health plans, budget documents, annual reports, and letters of review from local mental health advisory committees (LMHACs) and CSA advisory boards.

Indicators:
- Plans submitted from each CSA
- Compliance with MHA planning guidelines for CSA Plans evaluated
- Letters of review and recommendation received from each LMHAC and/or CSA board
- Previous fiscal year annual reports received
- MHA letter of review sent to the CSAs

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Cynthia Petion, MHA Office of Planning, and Training; Alice Hegner, MHA Office of CSA Liaison; MHA Office of Administration and Finance; MHA Review Committee (includes representatives of all major MHA offices); CSAs; LMHACs; CSA advisory boards

MHA Monitor: Cynthia Petion, MHA Office of Planning and Training

FY 2012 activities and status as of 6/30/2012 (end-year report):
Each year an extensive plan development process is implemented, beginning in January, with the submission, to the MHA, of local mental health plans and budgets from the Core Service Agencies (CSAs). The CSA Plan and Budget guidelines are developed through MHA's Office of Planning and Training to guide the development of local plans that identify priorities, strengths, needs and service gaps of the local public mental health system as well as a description of stakeholder input. An official comprehensive Plan is submitted by each CSA every three years with updated documents developed and submitted during the two years in between. To simplify data submissions, each CSA continued to include standardized data templates in its submission. This year, the templates included data from the Outcomes Measurement System from each jurisdiction.

In FY 2012, The CSAs' FY 2013-2015 Mental Health Plan and Budget documents were submitted to MHA and reviewed by a committee consisting of 12-15 MHA staff. Documents were submitted in the formats of either three-year plans or first or second year plan updates so that all CSA Plan submissions are scheduled on a continuum rather than have the MHA review staff review all comprehensive plans at one time. Each plan included, as required, a letter of review with recommendations from the local mental health advisory committee of that jurisdiction or documentation of review from the CSA Board of Directors.

CSAs were also required to submit their fiscal year 2011 Annual Reports. For the past five years, the CSAs have been submitting the annual report documents electronically. The plans and annual reports included discussions of the CSAs' achievements, interagency collaborations and partnerships, local and statewide initiatives, and financial plans linked to mental health services. Three-year plans included needs assessments, the findings from which were linked to goals and strategies. All plans were found to be in compliance with MHA's Guidelines Regarding Fiscal Year 2013-2015 Plans/Budgets. Letters of Review/approval were sent in the summer of 2012.

Strategy Accomplishment:
This strategy was achieved.

(6-2D)
Monitor and collect documentation on each CSA's performance of its duties, as required in the annual Memorandum of Understanding (MOU), on risk-based assessment of each CSA through a sample of specific MOU elements; and notify the appropriate MHA program director of issues that may require corrective action or additional technical assistance.
Indicators:
- Development and update of monitoring tools and instructions for reports from each CSA, emphasizing electronic transmission
- Reports from each CSA reviewed, in response to periodic instructions issued, regarding its administrative duties and expenditures, the execution of its subvendors' contracts, year-to-date expenditures/performance measures, and any required audits
- Evaluation of compliance with the Conditions of Award for State General Funds and Federal Mental Health Block Grant funds
- Three reviews scheduled for the first, second and fourth quarters of the fiscal year
- Scheduled onsite visit or conference call time with each CSA to communicate the findings of the second and fourth monitoring review
- Written letter issued to each CSA regarding each periodic report
- Appropriate follow-up conducted as needed, additional documentation provided for any period as necessary
- An aggregated report prepared for MHA for each period monitored
- Information filed appropriately for each review period - either electronically, and/or by paper - per fiscal year, for each CSA, in accordance with the MHA's record retention schedule
Involved Parties: Alice Hegner, Sandy Arndts, and Richard Blackwell - MHA Office of CSA Liaison; appropriate MHA Office Directors; MHA staff; CSA staff
MHA Monitor: Alice Hegner, MHA Office of CSA Liaison

FY 2012 activities and status as of 6/30/2012 (end-year report):
The MHA Office of CSA Liaison conducted three quarterly monitorings in a combination of on-site and/or conference calls for all 19 CSAs for compliance with the MOU for FY 2012. (The fourth monitoring process consists of the MHA review of CSA Program Plans, Annual Reports, and Budgets.) Quarterly monitorings for each CSA's administration and for its subvendors, included:

- Review of the use of both state general funds and federal block grant dollars
- Report from each of the 19 CSAs submitted regarding the timely execution of their subvendor contracts
- Type of contract used
- Requirement for an audit, its due date, copy of audit review
- Administrative reports on selected elements of the MOU, and a fiscal update for year-to-date expenditures
- Performance measures with projections for the fiscal year for the CSA's administration and subvendors
- Review of the use of Consumer Support funds

In addition, a selected sample of subvendors' contracts at each CSA was reviewed, including the contract, budget for cost reimbursement, programmatic report from the subvendor, invoice, payment, audit (if required), documentation of the CSA's review of the audit, site visit by the CSA, and internal controls by the CSA.

The Office of CSA Liaison prepares three quarterly reports for MHA's Deputy Director for Community Programs and Managed Care, noting particular issues such as specific information and data aggregated from MHA monitoring regarding subvendor contracts, requirements for audits, site visits, internal controls at the CSAs, and congruence with the Conditions of Award in the MOU between the MHA and the CSA. In FY 2012, all CSAs were audited:

- Ninety-six percent of the subvendors completed audits as required
- Of all contracts reviewed, 93% showed evidence of applying internal controls
- CSAs validated all subvendor data reports by way of site visits
- There was 90% congruence between contract conditions and the conditions as contained in the MHA MOU conditions of award

MHA retains the documentation provided by the CSAs on file, providing both verbal feedback through scheduled conference calls and documentation of its findings for each CSA, copied to the MHA Management Committee and available for review in the MHA Office of CSA Liaison.

Strategy Accomplishment:
This strategy was achieved.

(6-2E)
Review MHA's budget and PMHS expenditures and services; implement corrective actions, as needed, to maintain operations within allocation.

Indicators:
- Quarterly expenditure management plans developed and reviewed
- Regular meetings held with MHA facility chief executive officers (CEOs)
- Expenditures and needs reviewed by clinical directors and financial officers

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Randolph Price, MHA Office of Administration and Finance; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Facility CEOs; clinical directors and financial officers

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Randolph Price, MHA Office of Administration and Finance

FY 2012 activities and status as of 6/30/2012 (end-year report):
Expenditure plans and reports are developed and reviewed and MHA monitors facility budgets regularly. Also, MHA and the ASO have reviewed weekly and quarterly expenditure and utilization reports to ascertain trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, and correcting any problems that may be identified. Additionally, the CSAs routinely review various Crystal Reports detailing claims and utilization for consumers and providers within their respective counties.

The current economic crisis has had a significant impact on the State of Maryland. With declining state revenues and increasing demands for services, the state budget and the PMHS have been challenged. In FY 2012, numerous budget meetings/reviews were conducted involving MHA Headquarters, Facilities, and DHMH personnel. Operations were adversely impacted by funding constraints compounded by increased enrollment of Medical Assistance (MA) eligible consumers. This was offset, in part, by supplemental funding.

Insufficient funding in FY 2012 was minimal compared to FY 2011. Efforts continue to be monitored in the PMHS including the review of individuals who are uninsured to determine if applicable entitlement benefits have been received. This includes the Primary Adult Care (PAC) program. Uninsured individuals enrolled in the PAC now have MA coverage for most mental health care (excluding hospital emergency room service, inpatient, and outpatient hospital-based services).

Another significant result of the current budget processes is a long-term, ongoing trend to promote less costly community-based services while continuing to meet the expanding demand for PMHS services. These efforts result in a lower average cost per individual consumer served and is reflected in the various utilization data reports monitored by MHA and the CSAs.

Strategy Accomplishment:
This strategy was achieved.

Objective 6.3. MHA, in collaboration with CSAs, state facilities, the administrative services organization (ASO), and key stakeholders, will utilize data and technology, through a variety of approaches, to evaluate and improve the appropriateness, quality efficiency, cost effectiveness, and outcomes of mental health services within the PMHS.

(6-3A)
Continue to monitor the implementation of the Outcomes Measurement System (OMS).
Indicators:
  • Reestablishment of implementation of OMS monitoring, reporting, and feedback mechanisms including OMS expenditure analysis
  • Review of provider utilization rates; resolution of identified problems
  • Reestablishment of interactive OMS Web-based system (OMS Datamart) with refinements, including displays and reports that measure and reflect change-over-time analyses at the state, CSA, and provider levels
  • Provision of technical assistance to providers and CSAs regarding use of the OMS Datamart, once it is operational
Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Sharon Ohlhaver, MHA Office of Quality Management and Community Programs; Sheba Jeyachandran, MHA consultant; MHA Management Committee; ValueOptions®Maryland; CSAs; SEC; CBH; providers; consumer, family, and advocacy groups
MHA Monitor: Sharon Ohlhaver, MHA Office of Quality Management and Community Programs

FY 2012 activities and status as of 6/30/2012 (end-year report):
ValueOptions®Maryland, the University of Maryland SEC, and MHA collaborated to complete the multiple, complex tasks necessary to reestablish an interactive Web-based OMS Datamart. The first phase of the OMS Datamart went into production in August 2011. This included public access to statewide and county level data for FY 2011, CY 2010, and rolling-12 month point-in-time (PIT) data for both adult and child. This was followed by the remaining PIT years for both adult and child in December 2011.

The second phase of the datamart also went into production in December 2011. This included public access to statewide and county level change-over-time (COT) analyses for the years FY 2011 and CY 2010 for both adult and child, followed by the remaining years in February 2012. Provider-level data for all years, both PIT and COT, adult and child, became available in June 2012.

Demonstrations of the OMS Datamart have been made to DHMH Leadership, MHA Management Committee, MACSA, at the MHA Annual Conference, and the Maryland Advisory Council on Mental Hygiene/Planning Council. Several Webinars, focusing on provider-level data access and training, were also presented. Additionally, the CSAs were provided the OMS data for local/state comparison to enhance local mental health planning efforts.

Strategy Accomplishment:
This strategy was achieved.

(6-3B)
MHA will monitor the utilization of telemental health services to the underserved populations in the rural Western and Eastern Shore counties.
Indicators:
- Number of telemental health encounters through PMHS claims data
- Utilization of telemental health services monitored
- Data reviewed with designated area CSAs to inform planning

Involved Parties: Daryl Plevy, MHA office of the Deputy Director for Community Services and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; CSAs; ValueOptions®Maryland
MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

FY 2012 activities and status as of 6/30/2012 (end-year report):
MHA adopted regulations for telemedicine and received approval, on June 13, 2011, for Medicaid reimbursement from the Centers for Medicare and Medicaid (CMS) for telemental health services provided in rural/underserved counties. This allows distant site psychiatrists to be reimbursed for a psychiatric diagnostic interview, psychotherapy, and medication management. As of FY 2012, MHA has approved eight telemental health providers. Two are located in the rural Western counties, five are located on the Eastern Shore, and one is located in rural Southern Maryland.

The CSAs promote the development of a provider network in their jurisdictions. MHA monitors utilization through the number of unique individuals using telemental health services during each month.

Strategy Accomplishment:
This strategy was achieved.

(6-3C)
Enhance capacity for stakeholders to utilize PMHS data to measure service effectiveness and outcomes.
Indicators:
- Combined data efforts between MHA and CSAs maintained to evaluate current data system and data reports used for the purpose of policy and planning by CSAs and other stakeholders
- Input gathered from stakeholders on the practicality and efficacy of reports; technical assistance and regional trainings held as necessary
- Access to data increased to develop standard and ad hoc reports
- Expanded data usage opportunities to the public and stakeholders outside of MHA through the SEC
- Reports generated and posted to designated data reporting section on administrative Web site, making PMHS demographic data available to users outside of state agencies
- Promotion of managerial and county-wide access to dashboard reports and PMHS data through ASO reporting system
- Promotion of Outcomes Measurement System (OMS) as an effective tool to assist providers in management and planning efforts; technical assistance provided

Involved Parties: Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Cynthia Petion, MHA Office of Planning and Training; MHA Management Committee; ValueOptions®Maryland; SEC; CSAs; the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council; provider, consumer, family, and advocacy groups

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2012 activities and status as of 06/30/12 (end-year report):
PMHS quarterly reports are published for public consumption on the Administration's Web site www.dhmh.state.md.us/mha . With ValueOptions®Maryland, the current ASO, MHA created standardized policy to provide Ad hoc reports requested by CSAs to aide them in responding to suggested budget cuts and methods of combating projected budget strategies. Having the detailed data readily available has helped the CSAs track cost, service utilization, and management of Medicaid reimbursements. Monthly data and information technology (IT) conference calls with existing ASO were conducted to ensure proper execution of logic behind data reports and that all business rules are predefined. Reporting systems were fine tuned to promote ease of use. Additionally, quarterly reports and specialized data reports, as well as monthly StateStat reports are posted regularly to the Administration Web site.

In FY 2012, bi-monthly meetings were held to discuss data reports, trainings conducted to help with accessing data system, how to utilize the data for trending and analysis and to utilize existing reports for trouble-shooting or strategizing. Email alerts, presentations at Executive level meetings, dissemination of reports, and step-by-step instructions to access dashboard reports were sent out. Dashboard reports still remain available for Executive Level staff usage. Efforts continue to allow for the request of county-specific raw data sets to promote the analysis and use of PMHS data to coordinate planning efforts. Additionally, technical assistance in data usage opportunities was expanded to

the public and stakeholders outside of the MHA through the Systems Evaluation Center (SEC).

In efforts to further the PMHS system and the access of data to all stakeholders, the MHA Office of Management Information Systems (MIS) heads two monthly data-centered meetings. Representatives from MHA's MIS office and the Office of Planning and Training are present, as well as ASO, SEC and CSA members. The monthly meetings are used as a vehicle to filter data-specific information to all interested stakeholders, review and approve standard reports, and allow committee members the opportunity to make suggestions for the overall enhancement of the PMHS data system.

The Outcomes Measurement System (OMS) public Web-based datamart provides outcomes data at the county-specific level. Alerts and Web site notices, were used to promote trainings, and breakout sessions planned and presented at the 2012 MHA Conference. This presentation included brief explorations of the OMS site and how to use the data towards data planning and policy.

Strategy Accomplishment:
This strategy was achieved.

(6-3D)
Monitor the delivery of forensic services and generate statistical information to inform policy and promote public awareness.
Indicators:
- Number and results of court-ordered evaluations, the number and percentage of individuals in DHMH facilities on court order, and the number and success of consumers on court-ordered conditional release in the community
- Reports submitted to MHA Management Committee, the CSAs, and the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Involved Parties: Larry Fitch, Debra Hammen, and staff - MHA Office of Forensic Services; Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Susan Bradley, MHA Office of Management Information Systems and Data Analysis
MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2012 activities and status as of 6/30/2012 (end-year report):
Ongoing monitoring of more than 800 consumers on pre-trial and conditional release continued in FY 2012, including reports to the State's Attorney, as appropriate. It has been effective to enhance forensic services contracting through Harford County. MHA's Office of Forensic Services staff, in collaboration with the CSAs, collected data and outcomes for approximately 1,250 adult community-based court-ordered pre-trial evaluations, 110 presentence psychiatric evaluations, 45 presentence sex offender evaluations, and 110 juvenile court competency to proceed evaluations. These results were reported in FY 2012 to assist the CSAs and other PMHS leadership in planning efforts.

Committee reports and proceedings continue to be submitted regularly to MHA and the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council.

Strategy Accomplishment:
This strategy was achieved.

Objective 6.4. MHA, in collaboration with CSAs, the ASO, and key stakeholders, will promote the use of technology as a tool to improve information sharing, data collection, training, evaluation and performance, and outcomes.

(6-4A)
Enhance PMHS data collection and monitoring through continued activities to develop and/or refine management information systems.
<u>Indicators</u>:
- Technical aspects of management information systems refined; logic of reports enhanced to reflect recovery orientation and efficient use of service data; accuracy and usefulness of current reports identified
- Continued practices to promote data integrity for all PMHS data
- Continued promotion of Web-based OMS datamart for access to point-in-time and change-over-time information
- Continued data system integration efforts among behavioral health administrations (Mental Hygiene, Alcohol and Drug Abuse, and Developmental Disabilities)
- Strategies developed to identify and track users of services across administrations
- Continued leadership in Behavioral Health Data workgroup to promote relationships with other state agencies and data sharing

<u>Involved Parties</u>: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Sharon Ohlhaver, MHA Office of Quality Management and Community Programs; Cynthia Petion, MHA Office of Planning and Training; ADAA; DDA; SEC; DHMH's Information Resource Management Administration (IRMA); MA; CSAs; ValueOptions®Maryland; providers

<u>MHA Monitor</u>: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2012 activities and status as of 06/30/2012 (end-year report):
As the various data committees met throughout the current year they continued to critique and make recommendations to complete the assessment of all data reports. Monthly data and information technology conference calls with the ASO are conducted to ensure proper execution of logic behind data reports and reporting systems continue to be fine tuned to promote ease of use. Bi-monthly meetings are held to discuss data reports, conduct trainings to help with accessing data system, enhance the utilization of the data for trending and analysis, and to trouble shoot existing reports. DHMH continues to submit monthly hospital management information system data to National Association of State Mental Program Directors (NASMHPD) Research Institute (NRI) who shares the information with the Joint Commission to use as a part of its accreditation reviews.

Information Technology (IT) integration between ADAA and MHA has begun. MHA was asked to initiate the exploration of merging the IT departments of both administrations. In FY 2012, the IT Merge/Behavioral Health Data workgroup began the process of linking all administration computers to the Active Directory domain of ADAA in order to create a single Network directory among the two administrations. The integration of data systems, with Medicaid, ADAA and MHA, continues under guidance and direction of the DHMH Chief of Staff.

The Outcomes Measurement System (OMS) datamart has been re-launched. This has been a collaborative effort involving staff from MHA, the SEC, and the ASO. In FY 2012, Change over time (COT) data entered its last stages of validation and became ready for public reporting. All historical OMS data transferred between systems has been validated. Technical specifications and business rules have been established and approved. For further details see strategy 6-3A above.

Strategy Accomplishment:
This strategy is achieved.

(6-4B)
Maintain accreditation of MHA facilities by the Joint Commission.
Indicator:
  • All MHA facilities accredited
Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Arlene
     Stephenson, MHA Office of the Deputy Director for Facilities Management and
     Administrative Operations; Gayle Jordan-Randolph, MHA Office of the Clinical
     Director; MHA Management Committee; MHA Facility CEOs; appropriate
     facility staff
MHA Monitor: Mary Sheperd, MHA Office of the Deputy Director for Facilities
Management and Administrative Operations

FY 2012 activities and status as of 6/30/2012 (end-year report):
All MHA facilities have maintained their Joint Commission accreditation status. The state psychiatric facilities are significant participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland.

In FY 2012, the Management of Aggressive Behavior Workgroup was initiated and will continue to meet in FY 2013 to determine facility and staff needs and make recommendations. Also, Health and Safety Management Teams have been established at Springfield, Spring Grove, Eastern Shore, and Clifton T. Perkins Hospital Centers. These teams are collaborative efforts between facility management and direct care staff to develop action plans based on the data at their specific facility. Health and Safety Management Teams will be developed at other facilities in FY 2013.

The facilities have been supportive of the Consumer Quality Team, a project that protects and enhances rights by obtaining first hand information from consumers about their experiences in programs, as it added questions related to trauma-informed care (such as patient preferences for single or two gender situations) to its survey. This addition is in compliance with the requirements of the Senate Bill 556 Workgroup formed to increase safety at state facilities.

Strategy Accomplishment:
This strategy was achieved.

(6-4C)
MHA, in collaboration with the Developmental Disabilities Administration (DDA), will provide access to and ongoing training of appropriate MHA and DDA staff in the use of the hospital management information system (HMIS) and the Provider Consumer Information System 2 (PCIS2) data systems to better serve individuals with co-occurring diagnoses in MHA facilities and in the community.
Indicators:
- Programming of HMIS monitored and updated as appropriate
- Training in HMIS and PCIS2 systems ongoing for identified MHA and DDA staff
- Increased eligibility for discharge, expedient discharge process
- Collaboration facilitated among leadership at MHA, DDA, regional offices, and CSAs

Involved Parties: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHA Office of Consumer Affairs; Stefani O'Dea, MHA Office of Adult Services; Renata Henry, DHMH Deputy Secretary for Behavioral Health and Disabilities; DHMH IRMA; DDA; CSAs; MHA Facility CEOs
MHA Monitors: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations

FY 2012 activities and status as of 6/30/2012 (end-year report):
The PCIS2 System is the latest version of DDA's Management Information System. The hospital management information system (HMIS) utilized by the PMHS has been in the process of being revised to accommodate a report format that will help both MHA and DDA staff track individuals with co-occurring diagnosis and their eligibility. The joint database has been developed and meetings were held to further refine HMIS fields. A decision was made to further enhance the process of tracking DD eligible patients that are admitted to MHA facilities through a three part plan. Part one has been completed. DHMH's Office of IT created a DDA/ MHA match report that would be sent to MHA and DDA administrations monthly. It matches individuals who are found in HMIS with PCIS2 so that information is submitted monthly on patients in MHA facilities who have DDA eligibility.

Strategy Accomplishment:
This strategy was partially achieved.

(6-4D)
Increase public awareness and support for improved health and wellness through use of technology.
Indicators:
- Continuation of the Network of Care (www.maryland.networkofcare.org), a Web-based site promoting county specific resources for mental and behavioral health services throughout the state
- Specialized service information provided for Maryland's Youth, Veterans, and Families; work to improve upon existing formatting to create ease of system navigation and use
- Partnerships continued with county agencies and mental health entities to promote and expand features within the Network of Care site.

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Frank Sullivan, Director, Anne Arundel County Core Service Agency

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2012 activities and status as of 6/30/2012 (end-year report):
All of Maryland's 24 jurisdictions now have access to the Maryland Network of Care (NOC) for Behavioral Health. Information and resources in the communities and specialized service information is provided for Maryland's Youth as well as a special portal for Veterans and families to help service men and women returning from Iraq and Afghanistan, with behavioral issues, obtain access to services. CSAs have been encouraged to support, at the county level, the expansion and promotion efforts of NOC to more widely inform the mental health community regarding availability of the Web system. The use of NOC is encouraged and fostered in the Wellness and Recovery Centers, as well as other community settings, and plans are underway to train peer support specialists and peer educators to be able to train consumers on the use of NOC and to train consumers in the utilization of personal health record features and in the use of individual advance directives.

In FY 2012, the Maryland Network of Care for Behavioral Health has recorded 2,519,079 sessions. The veterans' portal recorded over 159,381 during the same time period. (www.maryland.networkofcare.org).

Strategy Accomplishment:
This strategy was achieved.

Appendix A

The Strategic Initiatives

The following eight Initiatives will guide SAMHSA's work from 2011 through 2014:

1. **Prevention of Substance Abuse and Mental Illness**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

2. **Trauma and Justice**—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

3. **Military Families**—Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

4. **Recovery Support**—Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

5. **Health Reform**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.

6. **Health Information Technology**—Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).

7. **Data, Outcomes, and Quality**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

8. **Public Awareness and Support**—Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Source: SAMHSA Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014, page 3.